UNIVERSIDADE FEDERAL DE SERGIPE
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AVALIAÇÃO DOS PACIENTES IDOSOS EM CUIDADOS PALIATIVOS NO SERVIÇO DE URGÊNCIA DO HOSPITAL UNIVERSITÁRIO DE LAGARTO

Lagarto – SE
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Trabalho de conclusão de curso apresentado ao Departamento de Medicina do Campus Prof. Antônio Garcia Filho da Universidade Federal de Sergipe como requisito parcial para obtenção do título de Médico.

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Aprovado em: ____/____/____

BANCA EXAMINADORA

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2º Examinador:

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RESUMO

O envelhecimento da população e o avanço das tecnologias aplicadas à saúde sem grande impacto na qualidade de vida vem tornando cada vez mais necessária a implementação de cuidados paliativos nas populações idosas para que se possa melhorar a qualidade da assistência a estes pacientes. Este estudo tem como objetivo avaliar o perfil dos pacientes idosos em cuidados paliativos internados na enfermaria do pronto socorro de um hospital universitário no período entre fevereiro e abril de 2019. Estudo transversal realizado no Hospital Universitário de Lagarto utilizando entrevistas com o paciente ou seu acompanhante, revisão do prontuário e aplicação das escalas de Charlson, Palliative Performance Scale e Escala de Karnofsky. Estavam aptos a participar do estudo os pacientes idosos internados nas enfermarias a partir urgência e com indicação de cuidados paliativos confirmados pelo escore NECPAL. Foram avaliados 30 pacientes. A maior parte dos pacientes foi indicada aos cuidados paliativos devido ao diagnóstico de síndrome demencial. Os pacientes foram internados principalmente devido a síndromes infecciosas. O valor médio do índice de comorbidade de Charlson 7,667. O nível de reserva funcional em geral foi baixo, sendo a média 16,33% calculada pelo PPS. Dos 29 pacientes com desfecho definido, 55,2% recebeu alta hospitalar e 41,7% evoluiu para o óbito. Foi observada correlação estatística e clínica entre o baixo nível de reserva funcional PPS (p=0,058) ou KPS (p=0,003) e o desfecho desfavorável. Síndromes demenciais foram as principais causas de indicação de cuidados paliativos. Não foi vista correlação entre idade e desfecho na internação e o nível de reserva funcional se correlacionou com o desfecho. Mais estudos são necessários para acompanhar os pacientes após a alta.

PALAVRAS-CHAVE: cuidados paliativos, idosos, demência

ABSTRACT

The increase in the age of the population and the advancement of technologies applied to health without great impact on the quality of life has made it increasingly necessary to implement palliative care in the elderly to improve the quality of care for these patients. This study aims to evaluate the profile of elderly patients in palliative care hospitalized in the emergency room of a university hospital. Cross-sectional study carried out at the University Hospital of Lagarto in the period between February and April 2019 using interviews with the patient or his companion, review of the chart and application of the Charlson scales, Palliative Performance Scale and Karnofsky Scale. The elderly patients admitted to the emergency room and with indication of palliative care confirmed by the NECPAL score were eligible to participate in the study. Thirty patients were evaluated. The majority of patients were indicated for palliative care due to the diagnosis of dementia syndrome. The patients were hospitalized mainly due to infectious syndromes. The mean value of the Charlson comorbidity index 7,667. The functional reserve level in general was low, the average being 16.33% calculated by the PPS. Of the 29 patients with a defined outcome, 55.2% were discharged from hospital and 41.7% died. Statistical and clinical correlation was observed between the low functional reserve level PPS ($p = 0.058$) or KPS ($p = 0.003$) and the unfavorable outcome. Dementia syndromes were the main causes of indication of palliative care, no correlation was found between age and outcome at admission, and the functional reserve level correlated with the outcome. More studies are needed to follow patients after discharge.

KEYWORDS: palliative care, the elderly, dementia

SUMÁRIO

1 REVISÃO DA LITERATURA

1.1 INTRODUÇÃO

Atualmente vem se observado o crescente envelhecimento da população mundial, e com isto o aumento da prevalência de doenças crônicas como câncer e doenças cardiovasculares, que possuem alta morbidade e mortalidade. Tal tendência vem sendo acompanhada do progresso da tecnologia médica, que possibilitou avanços em técnicas terapêuticas e levam ao prolongamento da vida em pessoas que antes teriam doenças fatais. Este fato também pode ser observado no Brasil, onde o envelhecimento da população e o número crescente de doenças crônicas limitantes têm se tornado uma realidade cada vez mais comum. O uso de técnicas mais avançadas por vezes leva a um aumento da sobrevida dos doentes, mas nem sempre esses avanços garantem a integralidade do tratamento e muitas vezes as sequelas geradas tornam-se os novos problemas do paciente, que passa a viver em uma condição limitada e com riscos de complicações. O manejo dessa população é complexo, especialmente quando as comorbidades atingem um ponto em que o prognóstico é reservado (Martins, N., 2009). Os cuidados paliativos visam melhorias na qualidade de vida do paciente a partir do momento do diagnóstico de doenças potencialmente fatais e de curso progressivo e irreversível. A aplicação de tal prática demanda conhecimento técnico por parte da equipe de saúde que presta assistência ao doente (Robinson, 2017).

Cuidados paliativos são definidos pela Organização Mundial de Saúde (OMS) como “cuidados ativos e integrais prestados a pacientes com doença, progressiva e irreversível, potencialmente letal, sendo fundamental o controle da dor e de outros sintomas através da prevenção e do alívio do sofrimento físico, psicológico, social e espiritual”. Tem como objetivo principal aliviar sintomas que comprometam a qualidade de vida, integrando ações médicas, de enfermagem, psicológicas, nutricionais, sociais, espirituais e de reabilitação, tendo influência direta no tipo de morte que o paciente terá (OMS, 2017).

1.2 PRINCÍPIOS DOS CUIDADOS PALIATIVOS

Segundo a Academia Nacional de Cuidados Paliativos (ANCP) (Martins, N., 2009), existem princípios que devem ser seguidos quando há a aplicação dos cuidados paliativos, sendo eles:

1. Promover alívio da dor e de outros sintomas desagradáveis
2. Afirmar a vida e considerar a morte um processo normal da vida
3. Não acelerar nem adiar a morte
4. Integrar os aspectos psicológicos e espirituais no cuidado ao paciente
5. Oferecer um sistema de suporte que possibilite ao paciente viver tão ativamente quanto possível até o momento da sua morte
6. Oferecer sistema de suporte para auxiliar os familiares durante a doença do paciente e o luto
7. Oferecer abordagem multiprofissional para focar as necessidades dos pacientes e seus familiares, incluindo acompanhamento no luto
8. Melhorar a qualidade de vida e influenciar positivamente o curso da doença
9. Iniciar o mais precocemente possível o Cuidado Paliativo, juntamente com outras medidas de prolongamento da vida, como quimioterapia e radioterapia, e incluir todas as investigações necessárias para melhor compreender e controlar situações clínicas estressantes

1.3 INDICAÇÕES DOS CUIDADOS PALIATIVOS

A OMS define que todos os pacientes portadores de doenças graves, progressivas e incuráveis, que ameacem a continuidade da vida, deveriam receber a abordagem dos Cuidados Paliativos desde o seu diagnóstico. No entanto, está não é a realidade atual, pois ainda não existem profissionais e serviços capazes de realizar a assistência paliativa em quantidade adequada para todos os pacientes que necessitam desta abordagem (Martins, N., 2009).

Atualmente os critérios discutidos para inclusão de um paciente em cuidados paliativos inclui o prognóstico de tempo de vida. Existem ferramentas objetivas capazes de avaliar o prognóstico de um doente, como o índice de Comorbidades de Charlson (Charlson, 1986), ou a indicação de cuidados paliativos com uma abordagem global, que considera aspectos referentes ao prognóstico, comorbidades e aspectos familiares, como o escore Necessidades Paliativas (NECPAL) (Gómez-Batiste, 2016). Muitas vezes o paciente com doenças limitantes

e potencialmente fatais não recebe orientações quanto ao significado de cuidados paliativos e quanto aos seus benefícios para ele, sendo que o medo desta abordagem frequentemente é identificado em pacientes e familiares, justificado pelo mito infundado de que a paliação implicaria abandono do doente por parte da equipe.

1.3.1 ÍNDICE DE COMORBIDADES DE CHARLSON

Este índice foi proposto por Mary Charlson e colaboradores em 1987, sendo criado com o objetivo de desenvolver um instrumento de prognóstico de comorbidades que individualmente ou em combinação podem interferir no risco de mortalidade a curto prazo de pacientes (Martins, M., 2008). O índice é composto por vinte condições clínicas selecionadas empiricamente com base no efeito sobre o prognóstico de pacientes internados num serviço de medicina geral dos Estados Unidos (Tabela 1) (Charlson, 1987). Há ainda a possibilidade de combinar o escore total a uma extensão que atribui pontos conforme a idade do paciente, permitindo estimar o risco de morte pelas comorbidades do paciente por idade (Tabela 2) (Rosas-Carrasco 2011).

Tabela 1 - Índice de Comorbidade de Charlson

Comorbidade	**Pontuação**
Infarto do miocárdio	1
Insuficiência Cardíaca Congestiva	1
Doença Vascular Periférica	1
Doença Vascular Cerebral (exceto hemiplegia)	1
Demência	1
Doença Pulmonar Crônica	1
Doença do Tecido Conectivo	1
Úlcera	1
Doença Hepática leve	1
Diabetes (sem complicações)	1
Diabetes (com lesão de órgão alvo)	2
Hemiplegia	2
Doença Renal moderada ou severa	2
Tumor Sólido Secundário (não metastático)	2
Leucemia	2
Linfoma, Mieloma múltiplo	2
Doença hepática moderada ou severa	3
Tumor Sólido Metastático	6
SIDA	6
Idade (anos)	**Pontuação**
50-59	1
60-69	2
70-79	3
80-89	4
90-99	5

Fonte: Charlson, 1987

Tabela 2 – Interpretação da Pontuação total + idade

Somatório da pontuação	Risco Relativo Estimado (IC > 95%)
0	1.00
1	1.45 (1.25 - 1.68)
2	2.10 (1.57 - 2.81)
3	3.04 (1.96 - 4.71)
4	4.40 (2.45 - 7.90)
5	6.38 (3.07 - 13.24)
6	9.23 (3.84 - 22.20)
7	13.37 (4.81 - 37.22)
≥ 8	19.37 (6.01 - 62.40)

Fonte: Rosas-Carrasco, 2011

1.3.2. NECPAL

O NECPAL é uma iniciativa da OMS em colaboração com a Universidade da Catalúnia cujo objetivo principal é identificação precoce de pessoas com necessidades de cuidado paliativos e prognóstico limitante da vida nos serviços de saúde para melhorar de forma ativa a qualidade de seus cuidados, com instalação gradual de uma abordagem paliativa que responda às necessidades do paciente.

As dimensões da ferramenta NECPAL permitem uma verificação multidimensional da abordagem, porém, embora dados recentes permitam identificar o risco de mortalidade a médio prazo, este utilitário deve ser usado com cautela, especialmente nos cuidados individualizados. Em serviços com alta prevalência de pacientes com condições crônicas potencialmente fatais, uma triagem deve ser realizada a fim de determinar prevalência dos pacientes-alvo, e promover a adoção sistemática de políticas de melhoria da qualidade dos cuidados paliativos (treinamento, mudanças da organização) (Gómez-Batiste, 2016).

Os procedimentos de aplicação do NECPAL incluem 3 etapas:

1. Produção de uma lista de pacientes com condições crônicas complexas de acordo com informações clínicas existentes (idade, diagnóstico, gravidade, uso de recursos, entre outros pontos) e conhecimento dos pacientes.
2. Pacientes alvo: “Crônicos com impacto especial de suas condições” com grave impacto, progressão, polifarmácia, multimorbidade, ou alta demanda.
3. Aplicação do Índice NECPAL (Figura 1): Pergunta Surpresa + outros parâmetros

Há ainda recomendações gerais que devem ser seguidas para a aplicação do NECPAL:

- Uso de parâmetros clínicos baseados na experiência e conhecimento do paciente complementado com instrumentos validados
- Profissionais: médicos e enfermeiros conhecendo a evolução do paciente
- Ambiente: qualquer serviço do sistema (não recomendável em casos de emergência sem conhecer o paciente, ou em enfermarias antes de 3 dias de internação)
- Requisitos: conhecimento do paciente e da evolução
- Uso de critérios e parâmetros clínicos (sem necessidade de outras explorações complementares)
- Interdisciplinaridade recomendada (médico e enfermeiro, com a participação de outros profissionais)

Dentro da escala NECPAL, para avaliar status funcional, é usado o índice de Karnofsky (KPS) (Tabela 3), que foi descrito inicialmente como um instrumento objetivo para documentar o declínio clínico em pacientes com câncer, avaliando sua capacidade de realizar determinadas atividades básicas. A maioria dos pacientes com KPS inferior a 70% tem indicação precoce de cuidados paliativos, enquanto que o KPS abaixo de 50% sugere terminalidade, sendo elegíveis ao cuidado paliativo, a menos que exista um ganho benéfico caso a terapia curativa seja mantida, devendo estar ser disponível e tolerável (Martins, N., 2009).

O Paliative Performace Scale (PPS) (Tabela 4) é outra ferramenta disponível e com propósito similar, que foi desenvolvida em 1996 no Victoria Hospice Society, localizado no Canada, e atualizado em 2001. Esta escala foi elaborada com base no KPS e adaptado aos cuidados paliativos. A escala possui 11 níveis divididos em intervalos de 10 em 10, sem níveis intermediários. Esta escala deve ser aplicada diariamente em pacientes internados, em todas as consultas ambulatoriais e em visitas domiciliares, podendo ser criado um gráfico pode ser útil para acompanhar as respostas do paciente as medidas adotadas no cuidado paliativo (Martins, N., 2009).

Figura 1 - Índice NECPAL

Pergunta surpresa (para / entre profissionais)	**Você ficaria surpreso se esse paciente morresse no próximo ano?**		**Não (+) Sim (-)**
	Pergunta ao familiar mais próximo		
"Demanda" ou "necessidade"	Demanda: o paciente, a família ou a equipe solicitou de forma implícita ou explicita cuidados paliativos ou limitação do esforço terapêutico?		Sim/Não
	Necessidade: identificado por profissionais de saúde da equipe		Sim/Não
Indicadores clínicos gerais: 6 meses -Grave, sustentado, progressivo, não relacionado com processo concorrente recente -Combina gravidade com progressão	Declínio nutricional	Perda de peso > 10%	Sim/Não
	Declínio funcional	- Karnofsky ou Barthel > 30% - Perda > ADLs	Sim/Não
	Declínio cognitivo	Declinio no minimental/Pfeiffer	Sim/Não
Dependência severa	Karnofsky < 50 ou Barthel < 20		Sim/Não
Síndromes geriátricas	- Quedas - Disfagia - Infecções recorrentes - Úlcera por pressão - Delírium	Registro no prontuário - Recorrente > 2 - ou persistente	Sim/Não
Sintomas persistentes	Dor, fraqueza, anorexia, dispneia, digestivo...	Checklist de sintomas (ESAS)	Sim/Não
Aspectos psicossociais	Aflição e/ou desordem adaptativa grave	Escala de malestar emocional (DME) > 9	Sim/Não
	Vulnerabilidade social severa	Avaliação social e familiar	Sim/Não
Multi morbidades	>2 doenças crônicas (da lista de indicadores específicos)	Índice de Charlsson	Sim/Não
Uso de recursos	Avaliar a demanda / intensidade das intervenções	- > 2 entradas urgentes ou não planejadas nos últimos 6 meses - Aumentar a demanda / intensidade de intervenções (cuidados domiciliares, intervenções de enfermagem, etc.)	Sim/Não
Indicadores específicos	Câncer, DPOC, DAC, hepatopatia, nefropatia, doença cerebrovascular, demência, doença neurodegenerativa, AIDS, outras avançadas		Sim/Não

Fonte: Gómez-Batiste, 2016

Tabela 3 – Escala de Karnofsky

%	Critério
100	Sem sinais ou queixas, sem evidência de doença
90	Mínimos sinais e sintomas, capaz de realizar suas atividades com esforço
80	Sinais e sintomas maiores, realiza suas atividades com esforço
70	Cuida de si mesmo, não é capaz de trabalhar
60	Necessita de assistência ocasional, capaz de trabalhar
50	Necessita de assistência considerável e cuidados médicos frequentes
40	Necessita de cuidados médicos especiais
30	Extremamente incapacitado, necessita de hospitalização, mas sem iminência de morte
20	Muito doente, necessita de suporte
10	Moribundo, morte iminente

Fonte: Schag, 1984

Tabela 4 – Paliative Performace Scale

%	Deambulação	Atividade e evidencia de doença	Autocuidado	Ingesta	Nível da consciência
100	Completa	Atividade normal e trabalho, sem evidência de doença	Completo	Normal	Completo
90	Completa	Atividade normal e trabalho, alguma evidência de doença	Completo	Normal	Completo
80	Completa	Atividade normal com esforço, alguma evidência de doença	Completo	Normal ou Reduzida	Completo
70	Reduzida	Incapaz para o trabalho, doença significativa	Completo	Normal ou Reduzida	Completo
60	Reduzida	Incapaz para hobbies/ trabalho doméstico, doença significativa	Assistência ocasional	Normal ou Reduzida	Completo ou períodos de confusão
50	Maior parte do tempo sentado ou deitado	Incapacitado para qualquer trabalho, doença extensa	Assistência considerável	Normal ou Reduzida	Completo ou períodos de confusão
40	Maior parte do tempo acamado	Incapaz para a maioria das atividades, doença extensa	Assistência quase completa	Normal ou Reduzida	Completo ou sonolência, +/- confusão
30	Totalmente acamado	Incapaz para qualquer atividade, doença extensa	Dependência completa	Normal ou Reduzida	Completo ou sonolência, +/- confusão
20	Totalmente acamado	Incapaz para qualquer atividade, doença extensa	Dependência completa	Mínima a pequenos goles	Completo ou sonolência, +/- confusão
10	Totalmente acamado	Incapaz para qualquer atividade, doença extensa	Dependência completa	Cuidados com a boca	Sonolência ou coma, +/- confusão
0	Morte	-	-	-	-

Fonte: Victoria Hospice Society, 2003. Tradução livre de Maria Goretti Maciel/Ricardo Tavares de Carvalho

2 ARTIGO (VERSÃO EM INGLÊS)

EVALUATION OF ELDERLY PATIENTS IN PALLIATIVE CARE IN AN EMERGENCY SERVICE OF THE LAGARTO UNIVERSITY HOSPITAL

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INTRODUCTION

The current aging of the population has been accompanied by an increase in the prevalence of chronic diseases. This fact is defined as the epidemiological and demographic transition observed in recent years in Brazil, evidenced by the reduction in the prevalence of infectious diseases and the increase in the prevalence of chronic non-transmissible diseases[1]. Alongside this fact, we can also observe the advances in health technologies that aim to prolong life, with a reduction in mortality due to chronic diseases, but with little impact on morbidity. In addition, they are not always cost-effective and burden health services[2].

In order to reduce the indication of invasive methods and with little impact on the survival of patients, palliative care has been increasingly applied in different populations with chronic diseases, with several indications[3]. Some tools that can be used for your indication. One example is the NECPAL, an initiative of the World Health Organization in collaboration with the University of Catalonia whose main objective is early identification of people with palliative care needs and a limiting prognosis of life in the health services. Thus, the quality of their care can be actively improved, with the gradual installation of a palliative approach that responds to their needs[4]. Another tool that can be used to assess the need for palliative care is the Charlson Comorbidity Index, which was created in 1987 with the objective of developing an instrument for the prognosis of comorbidities that individually or in combination may interfere with the risk of short-term mortality of patients[5,6,7].

Patients in palliative care need to be followed periodically with the goal of improving their well-being and quality of life. Tools such as the Palliative Performance Scale (PPS) and Karnofsky Scale (KPS) can be used to measure functional status and verify the need for support[8,9].

AIM

This study aimed to evaluate the elderly patients in palliative care in a secondary health center, the University Hospital of Lagarto (Monsenhor João Batista de Carvalho Daltro), located in Lagarto, Sergipe, Brazil. Secondary objectives are to identify the reasons for which palliative care was indicated, to verify the indications of hospitalization of these patients, to calculate by the Comorbidity Index of Charlson[5,6,7] the prognosis of these patients, evaluate the degree of functional status by the Paliative Performace Scale (PPS)[8] and Karnofsky Scale[9], and finally, to monitor the outcome of the cases followed during hospitalization.

METHODS

This is a cross-sectional study carried out in the city of Lagarto, Sergipe, at the University Hospital of Lagarto (Monsenhor João Batista de Carvalho Daltro) between February and April 2019.

Definitions and participants

Were eligible to participate in this study Patients above 60 years old who were admitted to the emergency room of the University Hospital of Lagarto (HUL), Sergipe, in the period between February and April 2019. They were indicated for palliative care and / or end-of-life care confirmed by NECPAL[4].

Data were collected through interviews and the application of validated questionnaires in patients, relatives and assistant staff, as well as the review of the patient charts after signing the Free and Informed Consent Term by the patient or by the legal guardian in cases of the impossibility of the interviewee to sign. Among the variables that were analyzed were age, sex, baseline comorbidities including the diagnosis that led to the indication of palliative care, diagnosis that justified the patient's hospitalization in the emergency room, the prognosis calculated by the comorbidities index of Charlson[5, 6,7], the NECPAL evaluation of the patient, the functional evaluation scores PPS and KPS[8,9] and the outcome.

Statistical analysis

The data obtained were tabulated in the Microsoft Excel software in the professional version plus 2013, and the statistical analysis was performed in the Bioestat software version 5.3, using the T test and the Pearson correlation coefficient.

RESULTS

In the study, 30 patients who were hospitalized at the Hospital Universitário de Lagarto were evaluated. All patients were older than 60 years and indication of palliative care by the NECPAL score[4]. These participants were evaluated and followed up by the hospital's palliative care team, and participated in this study responding to an interview for the application of the PPS and KPS scores. Identification data and diagnoses were correlated with the medical record. All patients, or in case of their impossibility, their legal representatives, agreed to participate in the study and signed the consent term. Among the patients followed up, 29 had a defined outcome until the closing date of this study, but one patient was still hospitalized. He was excluded from the analysis of the outcome.

Profile of assessed patients

Among the participants, there were a greater number of male patients, corresponding to 60.0% of the sample, while the female patients represented 40.0%. The mean age of participants was 85.5 years, with the oldest patient being 101 years old and the youngest being 66 years old. The patients were organized into groups corresponding to an age group (Table 1), and the group with the highest number of representatives was the age group between 80 and 89 years, with 15 patients (50.0% of the sample).

Table 1 - Distribution of patients age groups

Age group	**n**	**%**
60-69	1	3,3
70-79	5	16,7
80-89	15	50,0
90-99	8	26,7
100 or more	1	3,3
Total	30	100

Source: prepared by the author

The origin of the patients was restricted to the states of Sergipe and Bahia, with 28 patients originating in the first, and 2 in the second. The largest portion had the origin of the municipality of Lagarto, where the hospital is located, corresponding to 19 patients (63.3%). The other origins include Salgado with 4 patients, Simão Dias 2 patients, Riachão, Poço Verde and Boquim (1 patient each) in the state of Sergipe, Adustina and Paripiranga (1 patient each) in the state of Bahia.

The patients had indication of palliative care for several reasons, being the most frequent dementia syndrome, representing 70.0% of the sample. The second most frequent cause was the diagnosis of neoplasia with distant metastasis, represented by 13.3% of the participants. Other causes identified in the indication of palliative care among the accompanying patients included ischemic or hemorrhagic cerebrovascular accident (10.0%), immobility and fragility syndrome without identified etiological diagnosis (3.3%), and advanced chronic obstructive pulmonary disease (3.3%).

Among the patients diagnosed with dementia syndrome (n = 21), the most frequently identified etiology was Alzheimer's Dementia, corresponding to 61.9% of the patients. The second cause was Vascular Dementia, corresponding to 23.8% of patients. 14.3% of the patients had mixed or undetermined dementia.

All patients were admitted to the hospital emergency department due to a clinical intercurrence resulting or not from their underlying disease, and when they were in the ward they were evaluated by the palliative care team. The majority of the admissions in the emergency room were due to an infectious condition (86.7%); there were 2 hospitalizations due to non-infectious gastrointestinal causes: digestive hemorrhage and intestinal constipation with obstruction; 1 due to ischemic stroke and 1 acute pulmonary edema (Table 2).

Table 2 - Clinical disorder leading to hospitalization in the emergency room

Reason for hospitalization	**n**	**%**
Infectious Causes	26	86,7
Non-infectious gastrointestinal causes	2	6,7
Stroke	1	3,3
Acute pulmonary edema	1	3,3
Total	30	100

Source: prepared by the author

Among the 26 patients hospitalized for infectious causes, the most common reason was the diagnosis of pneumonia (50.0%), followed by urinary tract infection (26.9%), skin and soft tissue infection (15.4%), and acute gastroenterocolitis (7.7%).

Analysis of the Charlson Comorbidity Index

The mean value of Charlson's comorbidities index was 7.667, with a maximum of 18 and a minimum of 4. The mean comorbidities per patient was 2.06. There was no significant correlation between the value of the index and the outcome of the patient, but it is worth

mentioning that this score evaluates the prognosis in 1 year for the patient, and is not considered a predictor of mortality in a single hospitalization as was the case of the patients studied.

11 patients had scores greater than or equal to 8 on the Charlson Comorbidity Index, which corresponds to a relative risk 19,37 (6.01 - 62.40)[5,6] mortality in 1 year. The other patients scored between 4 and 7 points (Table 3).

Table 3 - Risk classification according to the Charlson score

Score in the Charlson Comorbidities Index	n	Relative risk according to Charlson's classification (5,6)
0	0	1.00
1	0	1.45 (1.25 - 1.68)
2	0	2.10 (1.57 - 2.81)
3	0	3.04 (1.96 - 4.71)
4	2	4.40 (2.45 - 7.90)
5	4	6.38 (3.07 - 13.24)
6	6	9.23 (3.84 - 22.20)
7	5	13.37 (4.81 - 37.22)
≥ 8	11	19.37 (6.01 - 62.40)

Source: prepared by the author

The comorbidity most frequently found was dementia, present in 70.0% of the patients, followed by hemiplegia (33.3%) and diabetes with target organ damage (23.3%). Other comorbidities include ulcers, metastatic solid tumor, congestive heart failure, diabetes without complications, peripheral vascular disease, moderate or severe chronic kidney disease, chronic lung disease and solid tumor without metastasis, in order of frequency (Table 4).

Table 4 - Comorbidities present in the evaluated patients

Comorbidity	Frequency	%
Dementia	21	70,0
Hemiplegia	10	33,3
Diabetes with complication	7	23,3
Ulcer	6	20,0
Metastatic solid tumor	4	13,3
Congestive heart failure	4	13,3
Diabetes without complications	4	13,3
Peripheral vascular disease	2	6,7
Moderate or severe chronic kidney disease	2	6,7
Chronic lung disease	1	3,3
Solid tumor without metastasis	1	3,3

Source: prepared by the author

Functional status evaluation

To evaluate the functional status, the PPS and KPS scores were used. The mean value of the functional reserve calculated by the PPS was 16.33%, and 19 patients (63.3% of the sample) had a functional reserve of 10%, that is, the majority of the patients were completely bedridden, incapable of any activity, with extensive disease, complete dependence, mouth care, drowsiness or coma, with or without mental confusion. 3 patients (10.0% of the sample) had a functional reserve of 20%, and 8 patients (26.7% of the sample) had a functional reserve of 30%. It was also observed that the greater the patient's age, the worse his functional reserve was calculated through PPS ($p = 0.057$).

Using the Karnofsky scale, 14 patients (46.7% of the sample) had a score of 20, that is, they were classified as "very ill, in need of support", 11 patients (36.7% of the sample) had a score of 10, classified as "moribund and with imminent death". 4 patients (13.3% of the sample) had a score of 30, classified as "extremely incapacitated, requiring hospitalization but not imminent death" and 1 patient (3.3% of the sample) had a score of 40, classifying it as "requiring special medical care".

Outcome

At the study conclusion date, 29 patients had a defined outcome. One patient had an indefinite outcome, that is, he remained hospitalized in the hospital ward, and therefore was excluded from the analysis below.

Among the 29 patients with defined outcome, 13 (44.8%) died during hospitalization and 16 (55.2%) were discharged with referral for ambulatory follow-up of palliative care. As far as male and female sex were concerned, 8 (47.1%) male patients died, while 5 (41.7%) female patients had this same outcome. 9 (52.9%) of the male patients and 7 (58.3%) of the female patients were discharged.

There was no statistically significant correlation between the age of the patient and the outcome ($p = 0.22$), but it was observed that the lower the functional reserve, the worse the outcome. The lower the functional status calculated by PPS, the worse the outcome ($p = 0.058$). Similar result was found when comparing the calculated score through the KPS scale, the score being lower, worse the outcome ($p = 0.003$).

DISCUSSION

A total of 30 patients were evaluated in the study, all of whom had indication of palliative care based on NECPAL. The surprise question used in NECPAL has reached a high degree of accuracy in recent studies, especially when applied in patients diagnosed with end-stage renal disease, neoplasias, congestive heart failure and sepsis[10]. A predominance of males was observed (60.0% of the sample). The mean age was 85.5 years, with the youngest patient being 64 years old, while the older patient was 101 years old. The most representative group were patients who were between 80 and 89 years old, representing 50.0% of the sample. The majority of the patients came from the State of Sergipe, with a predominance of patients from Lagarto and nearby region, which represented 63.3% of the sample, probably justified by the fact that this is the city where the hospital is located. Patients from other cities and states maintained the pattern of regional proximity, since even patients from Bahia came from cities near the state border (1 patient from Paripiranga-BA and 1 patient from Adustina-BA).

In previous studies, the most frequent indications for palliative care were related to neoplasia, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, dementia and acquired immunodeficiency syndrome[11,12]. The most frequent reason for indication of palliative care in this study was the diagnosis of a dementia syndrome, representing 70.0% of the sample. Of these patients, 61.9% had a diagnosis of Alzheimer's Dementia, 23.8% had a diagnosis of Vascular Dementia, and 14.3% had Mixed Dementia or of indeterminate cause. Other diagnoses that led to the indication of palliative care included ischemic or hemorrhagic stroke (10.0%), immobility and fragility syndrome without identified etiological diagnosis (3.3%) and advanced chronic obstructive pulmonary disease (3.3%).

In patients with advanced dementia syndrome, the progressive onset of dysphagia occurs, which in turn is related to pneumonia due to oral or gastric microaspirations to the airways[13, 14]. In hospitalized patients there is still the possibility of bladder catheterization, which may be related to urinary tract infections[15]. The reasons that led to hospitalization in the emergency were mainly related to infectious causes, which represented 86.7% of admissions. Pneumonia was the main infection identified, accounting for 50% of hospitalizations, followed by urinary tract infection, which accounted for 26.9%. Skin and soft tissue infections accounted for 15.4% of hospitalizations, and acute gastroenteritis 7.7%.

Among the other patients who were not hospitalized for infectious causes, 2 were hospitalized for gastrointestinal causes, one of them being diagnosed with gastrointestinal

bleeding and another with intestinal obstruction. There was also one hospitalization due to stroke and one due to acute pulmonary edema.

In an earlier study conducted in a hospital in Portugal evaluating the general population, the mean number of comorbidities per person was 1.6[16]. If it is taken into account that this study evaluated only the elderly population, it can be observed that there was an increase in the number of cormobidades with the increase of the age. The Charlson Comorbidity Index was calculated for all patients and had a mean value of 7.667. The highest and lowest score were 18 and 4 points, respectively. The mean comorbidities per patient was 2.06. The most common comorbidity was Dementia, present in 70.0% of the patients, followed by Hemiplegia present in 33.3% of the patients and Diabetes with target organ lesion present in 23.3% of the patients. Other identified comorbidities included, in order of frequency, Ulcer, Metastatic Solid Tumor, Congestive Heart Failure, Uncomplicated Diabetes, Peripheral Vascular Disease, Moderate or Severe Chronic Kidney Disease, Chronic Lung Disease, and Non-Metastasis Solid Tumor. It should be emphasized that we evaluated only the comorbidities included in the Charlson comorbidities index.

The functional reserve level calculated by the PPS and KPS scales remained low, being less than 40% in all patients. In PPS the value ranged from 10 to 30%, and 63.3% of the sample had a functional reserve of 10%. Using the KPS, 46.7% of the sample had a score of 20, which means "very ill, in need of support", and 36.7% had a score of 10, being classified as "moribund and with imminent death". Such functional decline has been observed in previous studies, especially when the end-of-life period approaches[17].

Of the 29 patients with outcome defined up to the conclusion of the study, 55.2% evolved to hospital discharge and 44.8% had a death outcome. Among both men and women, most of the patients were discharged. There was no statistically significant correlation between age and outcome, showing that there was no relationship between the age of the patient and the increase or decrease in the number of deaths ($p = 0.22$). The variable that correlated better with the outcome was the functional reserve calculated by PPS and KPS, and very low values of functional reserve were related to death ($p = 0.058$ and $p = 0.003$). It has been previously observed that higher values of functional reserve were associated with a higher hospital discharge rate[18]. Thus, it was concluded that the functional evaluation proved to be a good predictor for the outcome of urgent hospitalization in elderly patients in palliative care.

Limitations of the study

The study was conducted in a short period of time, which led to a low number of participants. There were also some cases of requests for advice from the palliative care team that could not be attended due to the patient's rapid evolution towards death, and these could not be evaluated.

CONCLUSION

It can be concluded that, in the University Hospital of Lagarto, among the patients in palliative care, there is a predominance of males. The most frequent illness that led to the indication of such care was dementia. The main causes of hospitalization were infectious syndromes, especially pneumonia. Among the total comorbidities, dementia was the most frequent, but patients with hemiplegia due to previous stroke, diabetes complicated by target organ damage and ulcer were also identified. The functional reserve level was generally low, and when calculated by PPS ranged from 10 to 30%, and by KPS from 10 to 40%. The most frequent outcome was hospital discharge with follow-up of outpatient palliative care. 46.7% of the patients had the death as an outcome. There was no direct correlation between age and outcome, but there was a clinical and statistical correlation between the functional reserve level and the outcome, being lower this level, calculated by PPS ($p = 0.058$) and KPS ($p = 0.005$), worse the outcome. More studies are needed to follow up the evolution of the patients who were discharged and to follow up the outcome in a longer period.

Declaration of conflicts of interest

The authors declare that there is no conflict of interest.

Ethical approval

Ethical approval was obtained from the Ethics Committee of the Federal University of Sergipe. (CAAE: 03399018.6.0000.5546, Ref: 3.144.456).

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3 ARTIGO (VERSÃO EM PORTUGUÊS)

AVALIAÇÃO DOS PACIENTES IDOSOS EM CUIDADOS PALIATIVOS NO SERVIÇO DE URGÊNCIA DO HOSPITAL UNIVERSITÁRIO DE LAGARTO

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INTRODUÇÃO

O envelhecimento crescente e atual da população vem sendo acompanhada do aumento da prevalência de doenças crônicas. Tal fato é definido como a transição epidemiológica e demográfica, observada nos últimos anos no Brasil, evidenciado pela redução da prevalência de doenças infectocontagiosas e aumento da prevalência das chamadas doenças crônicas não transmissíveis[1]. Junto a este fato, observa-se também o avanço das tecnologias aplicadas a saúde, que visam o prolongamento da vida, com redução da mortalidade pelas doenças crônicas, mas com pouco impacto na morbidade. Além disso, nem sempre são custo-efetivas e oneram os servidos de saúde[2].

Com o objetivo de reduzir a indicação de métodos invasivos e com pouco impacto na sobrevida de pacientes, os cuidados paliativos vêm sendo cada vez mais aplicados nas diferentes populações com doenças crônicas, sendo diversas as indicações[3]. Algumas ferramentas que podem ser usadas para sua indicação. Um exemplo é o NECPAL, que é uma iniciativa da Organização Mundial de Saúde em colaboração com a Universidade da Catalúnia cujo objetivo principal é identificação precoce de pessoas com necessidades de cuidado paliativos e prognóstico limitante da vida nos serviços de saúde para melhorar de forma ativa a qualidade de seus cuidados, com instalação gradual de uma abordagem paliativa que responda às suas necessidades[4]. Outra ferramenta que pode ser usada para avaliação da necessidade de cuidados paliativos é o Índice de Comorbidades de Charlson, que foi criado em 1987 com o objetivo de desenvolver um instrumento de prognóstico de comorbidades que individualmente ou em combinação podem interferir no risco de mortalidade a curto prazo de pacientes[5,6,7].

Os pacientes em cuidados paliativos precisam ser acompanhados periodicamente com o objetivo de melhorar seu bem estar e qualidade de vida. Ferramentas como o Paliative Performace Scale (PPS) e índice de Karnofsky (KPS) podem ser usadas para mensurar o status funcional e verificar a necessidade de suporte[8,9].

OBJETIVOS

Este estudo teve como objetivo principal avaliar os pacientes idosos em cuidados paliativos em um centro secundário de saúde, o Hospital Universitário de Lagarto (Monsenhor João Batista de Carvalho Daltro), localizado em Lagarto, Sergipe, Brasil. Como objetivos secundários estão identificar os motivos pelos quais os cuidados paliativos foram indicados, verificar as indicações de internação destes pacientes, calcular pelo Índice de Comorbidade de Charlson[5,6,7] o prognóstico destes pacientes, avaliar o grau de status funcional pelas escalas Paliative Performace Scale (PPS)[8] e Escala de Karnofsky[9], e por fim, acompanhar o desfecho dos casos acompanhados durante a internação.

MÉTODOS

Trata-se de um estudo transversal realizado na cidade de Lagarto, Sergipe, no Hospital Universitário de Lagarto (Monsenhor João Batista de Carvalho Daltro) no período entre fevereiro e abril de 2019.

Definições e participantes

Estavam aptos a participar deste estudo os pacientes acima de 60 anos que estiveram internados nas enfermarias do pronto socorro do Hospital Universitário de Lagarto (HUL), Sergipe, no período entre fevereiro e abril de 2019, e que tiveram indicação de cuidados paliativos e/ou cuidados de fim de vida confirmados pelo NECPAL[4].

Os dados foram coletados por meio de entrevistas e aplicação de questionários validados em paciente, familiares e equipe assistente, além da revisão dos prontuários dos pacientes avaliados, após assinatura do Termo de Consentimento Livre e Esclarecido pelo paciente ou pelo responsável legal em casos de impossibilidade do próprio entrevistado assinar. Entre as variáveis que foram analisadas estão a idade, o sexo, as comorbidades de base incluindo o diagnóstico que levou a indicação de cuidados paliativos, diagnóstico que justificou a internação do paciente na urgência, o prognóstico calculado pelo índice de comorbidades de Charlson[5,6,7], a avaliação pelo NECPAL do paciente, os escores de avaliação funcional PPS e KPS[8,9] e o desfecho.

Análise estatística

Os dados obtidos foram tabulados no software Microsoft Excel na versão professional plus 2013, e a análise estatística foi realizada no software Bioestat versão 5.3, por meio do teste T e o coeficiente de correlação de Pearson.

RESULTADOS

No estudo foram avaliados um total de 30 pacientes que estiveram internados no Hospital Universitário de Lagarto. Todos os pacientes tinham mais que 60 anos e indicação de cuidados paliativos pelo escore NECPAL[4]. Tais participantes foram avaliados e acompanhados pela equipe de cuidados paliativos do hospital, e participaram deste estudo respondendo a uma entrevista para a aplicação dos escores PPS e KPS. Os dados de identificação e diagnósticos foram correlacionados com o prontuário, conforme registrados pela equipe assistente. Todos os pacientes, ou no caso de sua impossibilidade seus representantes legais, concordaram em participar do estudo e assinaram o termo de consentimento livre e esclarecido. Entre os pacientes acompanhados, 29 tiveram desfecho definido até a data de fechamento desta pesquisa, porém 1 paciente ainda permanecia internado no hospital e foi excluído da análise do desfecho.

Perfil dos pacientes avaliados

Entre os participantes, houve um maior número de pacientes do sexo masculino, correspondendo a 60,0% da amostra, enquanto que as pacientes do sexo feminino representaram 40,0%. A média de idade dos participantes foi de 85,5 anos, sendo que o paciente de maior idade possuía 101 anos e o de menor idade 66 anos. Os pacientes foram distribuídos em grupos correspondentes a uma faixa etária (Tabela 1), sendo que o grupo com maior número de representantes foi a faixa etária entre 80 a 89 anos, com 15 pacientes (50,0% da amostra).

Tabela 1 – Distribuição dos pacientes faixas etárias

Faixa etária	**n**	**%**
60 a 69	1	3,3
70 a 79	5	16,7
80 a 89	15	50,0
90 a 99	8	26,7
100 ou mais	1	3,3
Total	30	100

Fonte: elaborada pelo autor

A procedência dos pacientes ficou restrita aos estados de Sergipe e Bahia, sendo que 28 pacientes tinham origem no primeiro, e 2 no segundo. A maior parcela tinha como origem o município de Lagarto, local onde o hospital fica localizado, correspondendo a 19 pacientes (63,3%). As demais origens incluem Salgado com 4 pacientes, Simão Dias 2 pacientes, Riachão do Dantas, Poço Verde e Boquim (1 paciente cada) no estado de Sergipe, e Adustina e Paripiranga (1 paciente cada) no estado da Bahia.

Os pacientes tiveram indicação de cuidados paliativos por diversos motivos, sendo o mais frequente o acometimento por uma síndrome demencial, representando 70,0% da amostra. A segunda causa mais frequente foi o diagnóstico de neoplasia com metástase a distância, representado por 13,3% dos participantes. Outras causas identificadas na indicação de cuidados paliativos entre os pacientes acompanhados incluíam: acidente vascular encefálico isquêmico ou hemorrágico (10,0%), síndrome de imobilidade e fragilidade sem diagnóstico etiológico identificado (3,3%) e doença pulmonar obstrutiva crônica em estado avançado (3,3%).

Entre os pacientes com diagnóstico de síndrome demencial (n=21), a etiologia identificada com maior frequência identificada foi a Demência de Alzheimer, correspondendo a 61,9% dos pacientes, e a segunda causa foi Demência Vascular, correspondendo a 23,8% dos pacientes. Dos demais, 14,3% dos pacientes tinham demência mista ou de causa indeterminada.

Todos os pacientes foram admitidos pelo serviço de urgência do hospital devido a uma intercorrência clínica decorrente ou não de sua doença de base, e quando estavam na enfermaria foram avaliados pela equipe de cuidados paliativos. A grande maioria das admissões na urgência foi devido a um quadro infeccioso (86,7%), houve ainda duas internações por causas gastrointestinais não infecciosas, sendo uma hemorragia digestiva e outra constipação intestinal com obstrução, uma por acidente vascular encefálico isquêmico e uma por edema agudo de pulmão (Tabela 2).

Tabela 2 – Distúrbio clínico que levou a internação na urgência

Motivo da internação	**n**	**%**
Causas infecciosas	26	86,7
Causas gastrointestinais não infecciosas	2	6,7
Acidente vascular encefálico	1	3,3
Edema agudo de pulmão	1	3,3
Total	30	100

Fonte: elaborada pelo autor

Entre os 26 pacientes internados por causas infecciosas, o motivo mais frequente foi o diagnóstico de pneumonia (50,0%), seguido de infecção do trato urinário (26,9%), infecção de pele e tecidos moles (15,4%) e gastroenterocolite aguda (7,7%).

Análise do índice de comorbidades de Charlson

O valor médio do índice de comorbidades de Charlson foi de 7,667, sendo o máximo 18 e o mínimo 4. A média de comorbidades por paciente foi de 2,06. Não houve correlação significativa entre o valor do índice e o desfecho do paciente, porém vale ressaltar que este

escore avalia o prognóstico em 1 anos para o paciente, e não é considerado um preditor de mortalidade em uma única internação como foi o caso dos pacientes estudados.

Entre os pacientes, 11 tiveram pontuação maior ou igual a 8 no Índice de Comorbidades de Charlson, que corresponde a um risco relativo 19,37 (6.01 - 62.40)[5,6] de mortalidade em 1 ano. Os demais pacientes pontuaram entre 4 e 7 pontos (Tabela 3).

Tabela 3 – Classificação de risco conforme o escore de Charlson

Pontuação no índice de Comorbidades de Charlson	**n**	**Risco relativo segundo a classificação de Charlson (5,6)**
0	0	1.00
1	0	1.45 (1.25 - 1.68)
2	0	2.10 (1.57 - 2.81)
3	0	3.04 (1.96 - 4.71)
4	2	4.40 (2.45 - 7.90)
5	4	6.38 (3.07 - 13.24)
6	6	9.23 (3.84 - 22.20)
7	5	13.37 (4.81 - 37.22)
≥ 8	11	19.37 (6.01 - 62.40)

Fonte: elaborada pelo autor

A comorbidade mais frequentemente encontrada foi demência, presente em 70,0% dos pacientes, seguida hemiplegia (33,3%) e diabetes com lesão de órgão alvo (23,3%). Outras comorbidades encontradas incluem úlceras de decúbito, tumor sólido metastático, insuficiência cardíaca congestiva, diabetes sem complicações, doença vascular periférica, doença renal crônica moderada ou severa, doença pulmonar crônica e tumor sólido sem metástase, em ordem de frequência (tabela 4).

Tabela 4 – Comorbidades presentes nos pacientes avaliados

Comorbidade	**Frequência**	**%**
Demência	21	70,0
Hemiplegia	10	33,3
Diabetes com lesão de órgão alvo	7	23,3
Úlcera de decúbito	6	20,0
Tumor sólido metastático	4	13,3
Insuficiência cardíaca congestiva	4	13,3
Diabetes sem complicações	4	13,3
Doença vascular periférica	2	6,7
Doença renal crônica moderada ou severa	2	6,7
Doença pulmonar crônica	1	3,3
Tumor sólido sem metástase	1	3,3

Fonte: elaborada pelo autor

Avaliação do status funcional

Para avaliação do status funcional foram usados os scores PPS e KPS. O valor médio da reserva funcional calculada pelo PPS foi de 16,33%, sendo que 19 pacientes (63,3% da amostra) possuía reserva funcional de 10%, ou seja, a maioria dos pacientes era totalmente acamado, incapaz para qualquer atividade, com doença extensa, dependência completa, cuidados com a boca, sonolência ou coma, com ou sem confusão mental. 3 pacientes (10,0% da amostra) possuía reserva funcional de 20%, e 8 pacientes (26,7% da amostra) possuía reserva funcional de 30%. Foi observado ainda que quanto maior a idade do paciente, pior era sua reserva funcional calculada através do PPS (p=0,057).

Usando a escala de Karnofsky, 14 pacientes (46,7% da amostra) tinham score de 20, ou seja, era classificado como “muito doente, com necessidade de suporte”, 11 pacientes (36,7% da amostra) tinham score de 10, sendo classificados como “moribundo e com morte iminente”, 4 pacientes (13,3% da amostra) possuam score de 30, classificados então como “extremamente incapacitado, necessitando de hospitalização, mas sem iminência de morte”, e 1 paciente (3,3% da amostra) possuía score de 40, o classificando como “necessitando de cuidados médicos especiais”.

Desfecho

Na data da conclusão do estudo 29 pacientes possuíam desfecho definido. Um paciente possuía desfecho indefinido, isto é, permanecia internado na enfermaria do hospital, e por isso foi excluído da análise a seguir.

Entre os 29 pacientes com desfecho definido, 13 (44,8%) evoluíram para o óbito durante a internação e 16 (55,2%) receberam alta com encaminhamento para seguimento ambulatorial dos cuidados paliativos. Quanto separados entre sexo masculino e feminino, 8 (47,1%) pacientes do sexo masculino evoluíram para o óbito, enquanto que 5 (41,7%) pacientes do sexo feminino tiveram este mesmo desfecho. Entre os demais, 9 (52,9%) dos pacientes do sexo masculino e 7 (58,3%) das pacientes do sexo feminino receberam alta.

Não houve correlação estatisticamente significativa entre a idade do paciente e o desfecho (p=0,22), mas foi observado que quanto menor a reserva funcional, pior o desfecho. Quando mais baixo foi o status funcional calculado pelo PPS, pior o desfecho (p=0,058). Resultado similar foi encontrado quando comparado o escore calculado através da escala KPS, sendo menor o escore, pior o desfecho (p=0,003).

DISCUSSÃO

Foram avaliados um total de 30 pacientes no estudo, sendo que todos possuíam indicação de cuidados paliativos com base no NECPAL. A pergunta surpresa usada no NECPAL obteve amplo grau de acurácia em estudos recentes, especialmente quando aplicada em pacientes com diagnóstico de doença renal terminal, neoplasias, insuficiência cardíaca congestiva e sepse[10]. Foi observado um predomínio do sexo masculino (60,0% da amostra). A média de idade foi de 85,5 anos, sendo que o paciente de menor idade possuía 64 anos, enquanto que o de idade mais avançada possuía 101 anos. O grupo com mais representantes foi o de pacientes que tinham entre 80 a 89 anos, representando 50,0% da amostra. A maioria dos pacientes eram procedentes do estado de Sergipe, sendo observado um predomínio dos pacientes procedentes de Lagarto e região próxima, que representou 63,3% da amostra, provavelmente justificado pelo fato desta ser a cidade onde hospital está localizado. Pacientes procedentes de outras cidades e estados mantiveram o padrão de proximidade regional, visto que mesmo os pacientes procedentes da Bahia vieram de cidades próximas a fronteira do estado (1 paciente de Paripiranga-BA e 1 paciente de Adustina-BA).

Em estudos anteriores as indicações mais frequentes de cuidados paliativos estiveram relacionadas a neoplasia, insuficiência cardíaca congestiva, doença pulmonar obstrutiva crônica, doença renal crônica, demência e síndrome da imunodeficiência adquirida[11,12]. Neste estudo, as indicações mantiveram o mesmo padrão, sendo a mais frequente o diagnóstico de uma síndrome demencial, representando 70,0% da amostra. Destes pacientes, 61,9% possuíam o diagnóstico de Demência de Alzheimer, 23,8% possuíam diagnóstico de Demência Vascular e 14,3% Demência Mista ou de causa indeterminada. Outros diagnósticos que levaram a indicação de cuidados paliativos incluíam Acidente Vascular Encefálico isquêmico ou hemorrágico (10,0%), síndrome de imobilidade e fragilidade sem diagnóstico etiológico identificado (3,3%) e Doença Pulmonar Obstrutiva Crônica em estágio avançado (3,3%).

Em pacientes com síndrome demencial em estágio avançado ocorre a instalação progressiva de disfagia, que por sua vez se relaciona com a pneumonia devido a microaspirações de conteúdo oral ou gástrico para as vias aéreas[13,14]. Em pacientes hospitalizados existe ainda a possibilidade de realização de cateterismo vesical, que pode estar relacionado a infecções do trato urinário[15]. Os motivos que levaram a internação na urgência do hospital giraram em torno principalmente das causas infecciosas, que representaram um total de 86,7% das admissões. Pneumonia foi a principal infecção identificada, representando 50%

das internações, seguido de infecção do trato urinário, que representou 26,9%. Infecções de pele e tecidos moles representaram 15,4% das internações, e gastroenterite aguda 7,7%.

Entre os demais pacientes que não foram internados por causas infecciosas, 2 foram internados por causas gastrointestinais excluindo causas infecciosas, sendo um deles diagnosticado com hemorragia gastrointestinal e outro com obstrução intestinal. Houve ainda uma internação por acidente vascular encefálico e uma internação por edema agudo de pulmão.

Em um estudo anterior realizado em um hospital de Portugal avaliando a população geral, a média de comorbidades por pessoa foi de 1,6[16]. Se levado em consideração que esse trabalho também foi realizado com a população idosa, em comparação com o presente estudo, houve um aumento no número de cormobidades com o aumento da idade. O Índice de comorbidades de Charlson foi calculado em todos os pacientes e teve como valor médio 7,667, com uma média de 2,06 comorbidades por paciente. A maior e a menor pontuação foram 18 e 4 pontos, respectivamente. A comorbidade mais frequente foi Demência, presente em 70,0% dos pacientes, seguido de Hemiplegia presente em 33,3% dos pacientes e Diabetes com lesão de órgão alvo presente em 23,3% dos pacientes. Outras comorbidades identificadas incluíam, em ordem de frequência, Úlcera de decúbito, Tumor Sólido Metastático, Insuficiência Cardíaca Congestiva, Diabetes sem complicações, Doença Vascular Periférica, Doença Renal Crônica moderada ou severa, Doença Pulmonar Crônica e Tumor Sólido sem metástase. Ressalta-se que foram avaliadas apenas as comorbidades incluídas no índice de comorbidades de Charlson.

O nível de reserva funcional calculado pelas escalas PPS e KPS manteve um padrão baixo, sendo menor que 40% em todos os pacientes. No PPS o valor variou de 10 a 30%, sendo que 63,3% da amostra possuía reserva funcional de 10%. Usando o KPS, 46,7% da amostra possuía escore de 20, o que significa paciente “muito doente, com necessidade de suporte”, e 36,7% possuía escore de 10, sendo classificado como “moribundo e com morte iminente”. Tal declínio funcional foi observado em estudos prévios, especialmente quando se aproxima do período de fim de vida[17].

Dos 29 pacientes com desfecho definido até a conclusão do estudo, 55,2% evoluiu para alta hospitalar e 44,8% teve como desfecho o óbito. Tanto entre homens quanto em mulheres, a maior parte dos pacientes recebeu alta. Não se observou correlação estatisticamente significativa entre a idade e o desfecho, mostrando que não houve relação entre a idade do paciente e o aumento ou diminuição do número de óbitos (p=0,22). A variável que se correlacionou melhor com o desfecho foi a reserva funcional calculada pelo PPS e KPS, sendo

que valores muito baixos de reserva funcional estiveram relacionados ao óbito (p=0.058 e p=0,003). Já foi observado anteriormente que valores mais elevados de reserva funcional estiveram associados a maior índice de alta hospitalar[18]. Deste modo, conclui-se que a avaliação funcional mostrou-se um bom preditor para o desfecho da internação de urgência em pacientes idosos em cuidados paliativos.

Limitações do estudo

O estudo foi realizado em um período curto de tempo, o que levou a um número baixo de participantes. Existiram ainda alguns casos de pedidos de parecer da equipe de cuidados paliativos que não puderam ser atendidos devido a evolução rápida do paciente para o óbito, e estes não puderam ser avaliados para inclusão no estudo.

CONCLUSÃO

Diante do exposto, pode-se concluir que no Hospital Universitário de Lagarto, entre os pacientes em cuidados paliativos, há um predomínio do sexo masculino. A doença mais frequente que levou a indicação desses cuidados foi a demência. As principais causas de internação foram as síndromes infecciosas, com destaque para pneumonias. Entre as comorbidades totais, novamente demência foi a mais frequente, mas também foram identificados pacientes com hemiplegia decorrente de AVE prévio, diabetes complicada por lesão de órgão alvo e ulcera. O nível de reserva funcional em geral foi baixo, sendo que quando calculado pelo PPS variou de 10 a 30%, e pelo KPS de 10 a 40%. O desfecho mais frequente foi a alta hospitalar com seguimento dos cuidados paliativos a nível ambulatorial. 46,7% dos pacientes tiveram o óbito como desfecho. Não houve correlação direta entre a idade e o desfecho, mas houve correlação clínica e estatística entre o nível de reserva funcional e o desfecho, sendo mais baixo este nível, calculado pelo PPS (p=0,058) e KPS (p=0,005), pior o desfecho. Mais estudos são necessários para dar continuidade ao acompanhamento da evolução dos pacientes que receberam alta e acompanhar o desfecho em um período mais prolongado.

Declaração de conflitos de interesse

Os autores declaram que não existe conflito de interesse.

Aprovação ética

Aprovação ética foi obtida do comitê de ética em pesquisa da Universidade Federal de Sergipe (CAAE: 03399018.6.0000.5546, Parecer: 3.144.456).

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ANEXO A – NORMAS DA REVISTA PALLIATIVE MEDICINE

***Palliative Medicine* Instructions to authors**

At *Palliative Medicine* we want to publish the highest possible quality of papers. Our instructions to authors therefore focus on what we want you to do to enhance the quality of your research reporting. We only have space for around 20% of papers submitted to us, so paying attention to high quality research reporting will enhance the chance of us being interested in your paper.

There are TWO mandatory uploads together with your paper: the reporting checklist for your study type and the authors' checklist to acknowledge that you have followed the instructions below.

These instructions to authors fall into four main sections.
First, an explanation of the type of papers we are interested in so you know you are writing for the right journal.
Second, a clear description of what we want to see in your writing which you will need to take account of when you are drafting your paper, to promote the highest possible quality of reporting.
Third, specific instructions on formatting etc., as well as more detail on reporting specifications to meet journal and publisher style requirements.
Fourth, information on how to submit your article and what happens after you have submitted it, including information on Open Access options and publicising your published paper.

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1. What type of papers do we want to publish?

a) *Palliative Medicine* is a highly ranked, peer-reviewed scholarly journal dedicated to improving knowledge and clinical practice in palliative care. It reflects the multi-disciplinary and multi-professional approach that is the hallmark of effective palliative care. Papers are selected for publication based on their scientific excellence, contribution to knowledge, and their importance to contemporary palliative care. We welcome papers relating to palliative care clinical practice, policy, theory and methodological knowledge.
b) *Palliative Medicine* is an international journal with authors, reviewers and readers from around the world. You must make sure that your work is contextualised for such a readership, and where research is conducted within a single country, how the results contribute to an international knowledge base.
c) *Palliative Medicine* is a research journal, and primarily publishes papers which report original research and systematically constructed reviews. We also publish short reports, service evaluations/audits, research letters and case reports occasionally, but if you are considering submitting these types of papers please take time to read our specific guidance on them below.
d) *Palliative Medicine* is the official research journal of the European Association for Palliative Care and a journal of the Association of Palliative Medicine. This Journal is a member of the Committee on Publication Ethics. This Journal recommends that authors follow the Uniform Requirements for Manuscripts Submitted to Biomedical Journals formulated by the International Committee of Medical Journal Editors (ICMJE).

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2. How do we want papers to be written?

All papers submitted to *Palliative Medicine* are scrutinised carefully by a number of members of the editorial team before being sent for external peer review. A substantial number are declined at this point, before peer review. Common reasons are that the papers report work which does not appear to be novel or does not add to knowledge

explicitly, or that the design or methods of the study are not appropriate to the question posed or poorly reported. We strongly suggest therefore that this information on writing and reporting is followed whilst drafting your paper, well before you consider submission to the journal, as there is evidence that this will enhance the clarity of your writing and message to readers. The SAGE Author Gateway has some general advice on how to get published, plus links to further resources.

a) ***Reporting guidelines***. All papers must be written following appropriate reporting guidelines, and a reporting guideline checklist indicating where required elements are found in the manuscript must be uploaded at the time of paper submission as a mandatory file (excluding research letters). A full list of reporting guidelines is found on the EQUATOR network website. Guidelines are known to improve the quality and comprehensiveness of research reporting, and we expect all relevant aspects of the guideline to be followed. Common guidelines include CONSORT (with any relevant extension) for trials, COREQ for qualitative research, PRISMA or ENTREQ for reviews. Interventional studies must also describe the intervention according to the TIDieR guidelines.

b) The ***key messages*** of the paper must be easy to see and interpret for readers. For this reason we ask you to pay close attention to the title, structured abstract and key statements. For some readers this may be all they look at to decide if they are interested in your paper, so they have to be informative, accurate, and meaningful to clinicians, researchers and policymakers. We have recommendations on titles, abstracts and key statements which are designed to improve the discoverability and usability of your papers and it is important that you read these and incorporate them into your manuscript.

c) Full details of ***ethics/research governance/data protection approvals*** must be given, with reference numbers, full names of the committee giving approval, and the dates of approvals. If research ethics committee/IRB approvals were not required for your work please reference the law or regulation granting exemption, and/or submit a letter from the relevant authorities granting this study exemption. This must be clear within the body of the paper. We expect in all circumstances that the highest possible standards of research ethics and governance are followed and demonstrated throughout the paper.

d) The ***discussion section*** of your paper must be structured, to enhance readers' ability to find the information about your work and its applicability. We ask that you provide clear subheadings which address:

i) ***Main findings/results of the study***: A short statement of the principal findings of the study should be presented.

ii) ***Strengths and weaknesses/limitations of the study***: A discussion of the strengths and weaknesses/limitations of the study with reference to other studies or reviews in this area.

iii) ***What this study adds:*** A discussion of what is already known about this topic area and what this research/review adds, and a clear discussion of the implications of the research/review for clinical practice, theory or methods in this area. We suggest that you raise further research or review questions.

Specific instructions on titles, abstracts, keywords and key statements for all papers

a) **Titles**. A significant proportion of readers come to the *Palliative Medicine* site by running simple searches. It is important therefore that an article's title, keywords and abstract are written to be optimally "discoverable" by search engines. You must ensure that the main key phrase for the topic is in the article title. Make sure the title is clear, descriptive, unambiguous, and accurate, and reads well. Titles must include details of the methods used

within the paper. We do not recommend the use of country names in titles as there is evidence this can restrict readership, countries can be mentioned in the abstract. There is evidence that putting the findings of the paper in the title can attract readership. An example of such a title would be: *Intervention A leads to a greater reduction in (primary) outcome x for people in their last year of life, compared to intervention B: A pragmatic randomised controlled trial*; or *The experience of X is challenging for family carers of people with advanced cancer: An ethnographic study*.

b) Abstract. Key tips for discoverability include repeating key phrases within the abstract and between the abstract and keywords – think about the key phrases you would type into a search engine if you were searching for the article. Repetition of a particular key phrase may strengthen the ranking of the article. Please read and follow these guidelines: http://www.uk.sagepub.com/authors/journal/readership.sp. Abstracts should not contain abbreviations or references. All our abstracts are structured, and should follow the formats below. There is some flexibility for audit/service evaluation as it is important that these are not presented as research:

i) ***Research Paper/Short Report/Audit/Service Evaluation abstract (250 words)***:

Background: Identify the issue to be addressed, current knowledge on the topic and some indication of its relevance and importance to clinical practice, theory or research methodology.

Aim: A clear statement of the main research aim(s), research question(s) or hypotheses to be tested.

Design: A statement about the research strategy adopted. For intervention studies, a clear statement of the intervention is required. For clinical trials, the trial number should be given. Give brief details of data collection methods. For interventional studies please add a sentence about the intervention tested.

Setting/participants: Indicate the type of setting(s) the research was conducted in (e.g. primary/secondary care), the number of centres, and who participated, including a brief indication of inclusion/exclusion criteria, numbers of participants and any relevant characteristics.

Results: Report the main outcomes(s) or findings of the study. If appropriate, report levels of statistical significance and/or confidence intervals.

Conclusions: Identify how the aims have been met, and the relevance of the findings for clinical practice, theory or research methodology. Give suggestions for further research.

ii) Systematically constructed review abstract (250 words)

Background: Identify the issue to be addressed, current knowledge on the topic and some indication of its relevance and importance to clinical practice, theory or research methodology.

Aim: A clear statement of the review aim(s).

Design: A statement about the review strategy/methods adopted (e.g. meta-ethnography, realist synthesis, systematic review, meta-analysis). If prospectively registered (e.g. on PROSPERO), this information should be given here.

Data sources: State the data sources used (including years searched). Include a statement about eligibility criteria for selecting studies and study quality appraisal.

Results: Report the main outcomes(s) /findings of the review.

Conclusions: Identify how the aims have been met, and the relevance of the findings for clinical practice, theory or research methodology.

iii) **Case Report and Case Series abstracts (200 words)**

Both abstract and full submission should follow the same structured format of:

Background (including existing evidence, literature and related cases in the public domain)

Actual case including details of the practice challenge and details of ethical review

Possible courses of *action*

Formulation of a *plan*

Outcome with timescales and how success /failure was judged

Lessons from the case

View on research problems, *objectives or questions* generated by the case

c) **Keywords.** Please give at least four key words, and up to eight. At least one should be subject-related, and at least one relate to your chosen research design. All keywords should be MeSH headings and should be checked against this list http://www.nlm.nih.gov/mesh/. Please provide a justification for any keywords which are not MeSH headings.

d) **Key statements**

Palliative Medicine has a system where all research and review papers (not letters) are required to state clearly what is already known about the topic, what the paper adds, and implications for practice, theory, or policy. You are required to give these at the start of the manuscript, as part of your manuscript text. Please use these three specific headings (see below), with 1-3 separate bullet points for each heading. Please use clear, succinct, single sentences for each bullet point rather than complex or multiple sentences.

What is already known about the topic?

Short statement(s) about state of knowledge in this area.

You may highlight both what is known and what is not known.

Be specific rather than making broad or sweeping statements. Avoid statements such as 'little is known about ... x or y' in favour of statements specifying exactly what is known.

What this paper adds

Short specific statement(s) about what this paper adds.

These should be styled in terms of outcomes where possible (This study demonstrates that x intervention has a (specific) impact on y outcome) rather than study aims or process, (This study considers whether x intervention has an impact of y outcome).

Be as specific as possible. Avoid broad statements such as 'New Knowledge is added about ... ', rather be specific about exactly what this knowledge is. For example, rather than 'We add to the knowledge base on x' we would prefer the more specific statement 'x variable was found to increase the experience of y outcome (by z amount)'.

Ensure that these statements clearly relate to the findings of the study.

Implications for practice, theory or policy

Short specific statement(s) on the implications of this paper for practice, theory or policy. These should clearly draw from the findings of the study, without over stating their importance. to an international readership.

Specific guidance on paper types and word limits

a) ***Review Articles*** – 5,000 words. The reviews we publish are usually systematically constructed reviews, clearly following the relevant publication guidelines (such as PRISMA, RAMESES or ENTREQ) for the particular review style chosen. We are happy to consider a range of review types (systematic reviews, meta-analysis, meta-ethnography, realist review for example) for publication, but they must be methodologically clear and rigorously conducted. If reviews are registered (e.g. on PROSPERO https://www.crd.york.ac.uk/PROSPERO/) this should be stated and a link given within the paper. Please ensure that you include a PRISMA type flowchart for all reviews to enable readers to understand your search processes. All reviews should include sufficient

detail on review question, inclusion and exclusion criteria, search strategies, data extraction and synthesis methods (as appropriate to the review design) for the study to be replicated. Please include a table of included studies. If some of these are large, you can consider adding them a supplementary online only files, but these must be referred to within the text of the review. Please note our specific requirements on review abstracts above.

b) ***Original Articles*** – 3,000 words with up to six tables or figures. Original articles must report robust, ethically conducted research. We publish research using a range of designs, as appropriate to the question posed. Please see general advice above for information on the relevant reporting guidelines which must be followed, and our title and abstract requirements. Please also look at instructions for short reports and research letters which may be a better 'fit' for papers reporting smaller pilot, exploratory or feasibility studies.

For trials and interventional studies, we expect that the intervention is fully described using accepted guidelines (e.g. TIDieR) as well as being reported according to the appropriate guidelines (e.g. CONSORT or one of its extensions). *Palliative Medicine* endorses the ICMJE requirement that clinical trials are registered in a WHO-approved public trials registry at or before the time of first patient enrolment. However, consistent with the AllTrials campaign, retrospectively registered trials will be considered if the justification for late registration is acceptable. The trial registry name and URL, and registration number must be included at the end of the abstract. If the protocol has been published this should be referenced within the paper.

For papers reporting qualitative methods we prefer papers which state their particular qualitative approach (e.g. grounded theory, phenomenology, ethnography etc.) and articulate their methodological (epistemological and ontological) position, how this relates to their question and design, and which present a so called 'thick' description and interpretation of their findings clearly. Participants' quotations may be excluded from the word count, and we prefer that they are integrated into the text rather than presented separately. We still prefer, however, that these quotations are succinct and carefully chosen – it is rare that more than one quote is required to illustrate the point being made.

Papers which report primarily the development or testing of scales/measures or questionnaires must include a copy of the relevant instrument as a supplementary file (with translation into English if appropriate, as well as in the original language), and such papers will not be accepted without such a file. Authors are expected to obtain any copyright permissions required for such reproduction.

For research articles, authors are required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal. Full details of all research ethics committee (e.g. IRB) and/or organisational governance approvals must be given within the body of the text with reference number and date of approval. If such approvals were not required, information about the exemption from this (and on what authority) must be given within the text of the paper.

The date(s) of data collection must be given within the paper. If your data were collected more than five years before submission we expect a strong justification for why reporting these results is still relevant to the *Palliative Medicine* readership.

c) ***Short reports*** – 1,000-1,400 words. These should report research, but are usually small scale survey/pilot/feasibility studies etc., which would not warrant a full original research paper. Please see the original article section above for general instructions.

d) ***Case & Case Series Reports*** - A good case report, or preferably a case series, can inform an important part of healthcare development and improvement through the creation of links from practice to research and back to practice. To do so it must provide close analysis of practice-based examples, giving insights into what happens in clinical and other practices when empirical evidence-based options have been exhausted, and identify potential 'golden nuggets' to signpost for further research exploration.

Palliative Medicine is a research journal. As such we are interested in case and case series reports which achieve these goals. We publish case reports to highlight issues of practical interest and identify research questions for further study. Research focused learning points must be explicit within the report.

We understand a case series can legitimately be identified and analysed retrospectively, particularly in areas of evolving and challenging practice. However, prospective planning of data collection will usually strengthen the findings and implications and if so if you are planning a case study series using prospective research methods please review this methodological paper http://journals.sagepub.com/doi/pdf/10.1177/0269216311419883 and consider whether to submit your work as a case series report or an original research article, with appropriate justification of your choice in your covering submission letter.

Essential elements of a case or case series report in *Palliative Medicine*:

- There must be a clear practice-based challenge that the report seeks to address: the challenge may be related to physical (e.g. medications and symptom control), social, psychological, spiritual or ethical issues but it must be a challenge faced in frontline palliative care practice.
- Evidence of reasonable international literature review, including other case reports or series on the same / similar subject matters must be included as must evidence of seeking to identify consensus of practice internationally regarding comparable cases.
- When similar cases or case series have been previously published then submitting authors are required to create a referenced case series from the previous cases as background to their own and to highlight how this informed actions in their own cases. In addition, submitting authors must justify how a further publication will take the field forward.
- The actual cases should be presented briefly (150 words or less is recommended) at the start of the submission, followed by up to four possible courses of action posed in response to the question 'What would you do next?'
- A clear explanation of how a plan was prospectively formulated to assess the options and manage the case must be given. This should include the theoretical basis of any interventions and the underpinning reasoning behind decision making.
- Explicit details of critical elements of the case should be given, while seeking to preserve anonymity of individual patients / other persons not included in the authorship of the submission. We expect the majority of cases to be anonymised to the extent that someone who knew the patient could still not positively identify them. If this is not possible, for example because specific details or photographs are required to present the case, then

there must be inclusion of a statement within the submission confirming that all individuals and organisations potentially identifiable from the case have agreed to its publication. Further to this, copies of written informed consent from patients and other non-professional members of the team as well as any professionals should be submitted as supplementary files. This must include the provisional title of the submission, consent for all material (including photos, images, text or other material) to appear in the Sage publication *Palliative Medicine* and related forms of publication such as, but not limited, social media associated with the journal, blogs and press releases. The person consenting must confirm they have seen the material, read the submission and that they are legally entitled to give their consent. They should confirm that they understand publishing of the material without their name attached does not guarantee complete anonymity as it is possible someone may recognise them or their case. They should confirm that they understand potential distribution is worldwide and access is not controlled by the journal or Sage, and also that they will not receive any financial benefit from publication. They must confirm that they understand consent cannot be revoked post publication and that their consent form will be retained securely by Sage.

- If the patient has died, we would expect the authors to request permission from a person with Lasting Power of Attorney or in the absence of LPA, a relative, and to make this clear on the consent form and in the submission. If no written consent is possible from either the patient or relative, we will consider the utility of the case carefully against the likelihood of identification or potential distress. It is likely that in this position more information will have to be removed from the case to reduce the possibility of identification, and this will have to be made clear in the submission.

- Details of any relevant ethical approval processes for interventions should be included. In the event of a submission describing an intervention not subject to formal governance or ethical review then authors should provide justification of the reasons for this e.g. not required in the local jurisdiction for this type of research, clinical cases were shared decision making took place for a novel management with a specific patient and set of clinicians in the absence of no other options and in response to an urgent need. It would still be expected that such cases would have been discussed, including potential ethical issues, among the clinical multidisciplinary team and an explanation of this and how the work/practice was conducted ethically and with integrity must included in the submission. Authors should include explanation of how any novel treatment was discussed with patients prior to use.

- We are particularly interested in how case / case series submissions might direct and instigate further research and ultimately lead to better evidenced practices:

    - The outcome of the case / case series with details of any outcome measures used should be given.

    - The case must conclude with a view on research problems, objectives or questions generated through the challenge of the case and how these might be addressed. In simpler terms this might be posed as answering a 'so what?' question.

- While not specifically excluded extremely rare cases are likely to be of less interest to our wider readership and so priority will be given to publishing cases that build a picture of contemporary practice and collective consensus on managing issues at the frontline of practice while awaiting further research evidence.

- Appropriate case / case series EQUATOR reporting guidelines should be used. See: https://www.equator-network.org/
- The submission must not exceed 1500 words plus 2 tables or figures, acknowledgements, 10 references, and a 200-word structured abstract plus separately three key learning points (written as 1-2 sentence bullet points) for practice / research.

Further requirements:

- Case reports / case series should include the words 'case report' or 'case series' as appropriate in the title and keywords. Please do not use 'case study' as this leads to confusion with the research strategy of the same name.
- Drug names should be generic not proprietary.
- Details of management should be specific and described to be understandable by those who may follow different protocols in different contexts.
- Both abstract and full submission should follow the same structured format of:
    - Background (including existing evidence, literature and related cases in the public domain)
    - Actual case including details of the practice challenge and details of ethical review
    - Possible courses of action
    - Formulation of a plan
    - Outcome with timescales and how success /failure was judged
    - Lessons from the case
    - View on research problems, objectives or questions generated by the case

e) **Practice Reviews** - can either be commissioned by the Editor in Chief or agreed by submission. For the latter an initial outline pitch of a practice review proposal should be submitted for consideration by the Editor in Chief by emailing Debbie.Ashby@bristol.ac.uk in the first instance rather than a submission being made directly through Manuscript Central. This should include a brief summary of the anticipated extent and quality of literature supporting the proposed review.

Not all submitted proposals will be accepted, and for those that are, there may be an informal work-up process required to reach agreement prior to the pitch being accepted. **The review must have its own novel research question that the authors seek to answer** (or if an update of a previous review, justification for why an update is needed e.g. significant time has elapsed and there is a significant body of new empirical evidence).

Once accepted pitched proposals will proceed in the same way as commissioned reviews. Commissioned reviews will occur a few times a year and may be related to themed issues, virtual issues or stand-alone. All reviews will be subject to peer-review, when possible by a member of the journal's Editorial Board in addition to external review.

The purpose of practice reviews is to provide a 'stock take' or overview of the current 'state of the science' in an area of practice with a supporting evidence-based summary of guidance and recommendations which can be drawn from evidence about what is known to be beneficial or not. Reviews might cover newly emergent 'hot topics' but equally might be the basis of establishing the need for further research in a long-established topic area by considering the evidence base on which current practices are based and what would take the field forward.

Practice review subjects can be clinical, ethical or relate to another aspect of palliative care such as spiritual, social or psychological care or professional development. Review subjects which are relevant to the shared practices of multidisciplinary teams are particularly welcome.

Reviews should both orientated to recommendations for frontline practice and identification of scientific equipoise, i.e. absence of studies, with suggestions for further research. The implications of the review findings must be considered from the perspective of policy-makers, researchers, clinicians, ethicists and funders of research or quality improvement interventions. Review authors should aim to give a clear steer on what might be the most important gaps to be addressed through further research.

Purely descriptive summaries of evidence will not be accepted.

We ask that these aims are achieved by following the structure below in order to generate learning for both our practitioner and researcher audience. We are very grateful to Erik Driessen, Editor-in-Chief, and Robert McKinley, Section Editor, *Perspectives on Medical Education* for letting us adapt the format (McKinley, R. & Scheele, F. Perspect Med Educ (2015) 4: 275. https://doi.org/10.1007/s40037-015-0230-8; https://www.springer.com/education+%26+language/journal/40037?detailsPage=editorialBoard).

Review presentation and structure - submitting authors should provide an overview of "Dos, Don'ts and Don't Knows" on a specific subject in clinical practice. Following a brief introduction, including the context, scope and methods used to conduct the review the remainder of the submission should be divided into a tabulated digest summarising each aspect of the evidence item by item and a review article providing the relevant supporting evidence, and indicating the strength of the evidence for each particular item.

- Dos – should be recommendations for practice that can be made with a supporting body of evidence for effectiveness or efficiency.
- Don'ts – should be recommendations against activities for which there is a supporting body of evidence to show inefficiency, ineffectiveness, or indeed harm.
- Don't knows – should be identified areas for further research as there is either an absence of evidence or the current evidence is unclear or not of convincing quality or rigour. Don't knows should be expressed as questions which if answered through further research would have an impact on clinical practice.

The digest table should be provided using this format:

Table 1. Summary of guidelines/recommendations for XXX

	Aspect A	Strength of recommendation
Do's		
Don'ts		
Don't knows		
	Aspect B	
Do's		
Don'ts		
Don't knows		

The choice of subject for the review should be guided by identification of the subject as an area of importance to clinical practice, in which there is some evidence for aspects of practice. The scope of

the review will vary from subject to subject but should be broad enough to take into account different settings, both in terms of considering an international audience and across different areas of palliative care, i.e. hospice, hospital and community. Within the subject the dos, don'ts and don't knows should be items of importance to practitioners and will usually relate to common choices and decisions required in providing clinical care for patients with particular symptoms or diseases. All items should be made as specific as possible. Authors are likely to find it helpful to collaborate as a team and to pull together a provisional list of do's, don'ts and don't knows prior to conducting their review of the evidence which can then be revised in the light of the review findings.

Authors are free to choose their own methodology and methods for the review process, but this must be justified and appropriate to the subject and review question chosen. Practice reviews should be consistent with relevant publication guidelines (such as PRISMA, RAMESES or ENTREQ) for the particular review style chosen. We are happy to consider a range of review types (systematic reviews, meta-analysis, meta-ethnography, realist review for example) for publication, but they must be methodologically clear and rigorously conducted. If reviews are registered (e.g. on PROSPERO https://www.crd.york.ac.uk/PROSPERO/) this should be stated and a link given within the paper.

Judgements about the strength of evidence should allow for multiple types of evidence to be considered so that readers are provided with an overview of what exists. Authors can choose their own framework for assessing the strength of evidence but the review should not be limited to particular types of studies. A useful guide to rating strength is below:

Strength of recommendation:

Strong:	A large and consistent body of evidence such as a systematic review
Moderate:	Solid empiric evidence from one or more papers plus the consensus of the authors
Tentative:	Limited empiric evidence plus the consensus of the authors

Review formatting and additional requirements

- In addition to the tabulated digest of recommendations and further research requirements, the main content of the review must not exceed 2000 words
- A PRISMA type flowchart should be included as a supplementary online file
- Included studies must all feature within the reference list and a further table detailing these should also be provided as a supplementary online file.
- Any limits on the timeframe of the review must be clearly justified.
- A structured abstract of 250 words or less must be provided. The structure should be:

Background: Identify the issue to be addressed, current knowledge on the topic and some indication of its relevance and importance to clinical practice, theory or research methodology.
Aim: A clear statement of the review aim(s) and / or research question it seeks to answer. Purely descriptive summaries of evidence not synthesised into do's, don'ts and don't knows will not be accepted.
Design: A statement about the review strategy/methods adopted (e.g. meta-ethnography, realist synthesis, systematic review, meta-analysis). If prospectively registered (e.g. on PROSPERO), this information should be given here. Use of appropriate quality framework / guidelines to conduct the review should be included.
Data sources: State the data sources used (including years searched). Include a statement about eligibility criteria for selecting studies and study quality appraisal. As a minimum a scoping review using recognised methods must be conducted.

Results: Report the main outcomes(s) /findings of the review. This should include key statements on answering the review question/aims, and the meaning of the findings.
Conclusions: Identify how the aims have been met, and the relevance of the findings for clinical practice, theory or research methodology.

f) ***Audit and Service Evaluation***. 1, 000 – 1,400 words. We accept audit and service evaluation reports, but these should be of *exceptional* quality and interest. They should be identified clearly as audit or service evaluation in the title. These should be reported robustly – we expect audits to discuss the audit cycle and feedback, and service evaluations to report sufficient contextual information on the service being evaluated. They should be used to raise future research questions. Full details of all relevant organisational permissions and consents should be reported.

g) ***Research letters***. Maximum 750 words. We occasionally publish short research letters (no abstract required, no more than three references). These are usually offered to authors submitting original papers or short reports which we feel should be disseminated, but in a more succinct form.

h) ***Letters to the editors***. Maximum 500 words. We welcome correspondence relating to issues of general interest to our readership, or in response to a publication. Such letters should be succinct, generally no more than 500 words. NB: word count excludes references, tables and figures' references. We discourage the use of abbreviations strongly unless these are internationally known and accepted. Papers which use non standard abbreviations to reduce word count will be asked to replace these in full, but still adhere to the word count. We particularly ask that there are no abbreviations in the abstract.

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3. Journal publishing and formatting requirements

Declarations. Authors should include a clear declarations section at the end of the manuscript. This should contain five sections on authorship, funding, conflicts of interest, ethics and consent and data sharing. You may also include an acknowledgements section.

Authorship. Papers should have a short section at the end identifying the roles of each author of the paper. Papers should only be submitted for consideration once consent is given by all contributing authors. Those submitting papers should check carefully that all those whose work contributed to the paper are acknowledged as contributing authors.
The list of authors should include all those who can legitimately claim authorship. This is all those who:
(i) Made a substantial contribution to the concept or design of the work; or acquisition, analysis or interpretation of data,
(ii) Drafted the article or revised it critically for important intellectual content,
(iii) Approved the version to be published,
(iv) Have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

Authors should meet the conditions of all of the points above. When a large, multicentre group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should meet the criteria for authorship fully.
Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship, although all contributors who do not meet the criteria for authorship

should be listed in the acknowledgments section. Please refer to the International Committee of Medical Journal Editors (ICMJE) authorship guidelines for more information on authorship.

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Declaration of conflicts of interest. It is the policy of *Palliative Medicine* to require a declaration of conflicting interests from all authors, enabling a statement to be carried within the paginated pages of all published articles. Please ensure that a 'Declaration of Conflicting Interests' statement is included at the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state 'The Author(s) declare(s) that there is no conflict of interest'.
For guidance on conflict of interest statements, please see the ICMJE recommendations here.

Research ethics and patient consent. Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki. Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals, and all papers reporting animal and/or human studies must state in the methods section that the relevant Ethics Committee or IRB provided (or waived) approval. Please ensure that you have provided the full name and institution of the review committee, in addition to the approval number.

For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal. Please also refer to the ICMJE Recommendations for the Protection of Research Participants

Data management and sharing. SAGE acknowledges the importance of research data availability as an integral part of the research and verification process for academic journal articles. *Palliative Medicine* requests all authors to provide detailed information in their articles on how the data can be obtained. This information should include links to third-party data repositories or detailed contact information for third-party data sources. Data available only on an author-maintained website will need to be loaded onto either the journal's platform or a third-party platform to ensure continuing accessibility. Examples of data types include, but are not limited to, statistical data files, replication code, text files, audio files, images, videos, appendices, and additional charts and graphs necessary to understand the original research. The editor may consider limited embargoes on proprietary data. The editor can also grant exceptions for data that cannot legally or ethically be released. All data submitted should comply with Institutional or Ethical Review Board requirements and applicable government regulations. For further information, please contact Debbie Ashby [Debbie.Ashby@bristol.ac.uk].

Acknowledgements. All contributors who do not meet the criteria for authorship should be listed in an acknowledgements section as described above. Examples of those who might be acknowledged

include a person who provided purely technical help, or a department chair who provided only general support.

General journal requirements, formatting, and referencing requirements

a) **Multiple publications, copyright and plagiarism.** We want our readers to be aware of other published or in-press accounts of any studies published in *Palliative Medicine*. For this reason we ask that all published and in-press accounts of the study from which data in your paper are taken must be referred to explicitly in your paper. Please make it clear in your manuscript that you are referring to data/publications from the same study. If you have other publications from the same study in preparation or under review please refer to this in your letter to the editor. If you are successful in your submission to *Palliative Medicine* we ask that where possible this publication should be referred to in other manuscripts using data from the same study.

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b) **Writing assistance**. Individuals who provided writing assistance, e.g. from a specialist communications company, do not qualify as authors and so should be included in the acknowledgements section. Authors must disclose any writing assistance – including the individual's name, company and level of input – and identify the entity that paid for this assistance. It is not necessary to disclose use of language polishing services. Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal's specifications should consider using SAGE Language Services. Visit SAGE Language Services on our Journal Author Gateway for further information.

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d) **Word processing formats.** The preferred format for your manuscript is Word. LaTeX files are also accepted. Word and LaTex templates are available on the Manuscript Submission Guidelines page of our Author Gateway.

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g) **Journal layout**. *Palliative Medicine* conforms to the SAGE house style. Click here to review guidelines on SAGE UK House Style.

h) **Reference style**. *Palliative Medicine* adheres to the SAGE Vancouver reference style. View the SAGE Vancouver guidelines to ensure your manuscript conforms to this reference style. If you use EndNote to manage references, you can download the SAGE Harvard EndNote output file [OR] the SAGE Vancouver EndNote output file

i) **Corresponding author contact details**. Provide full contact details for the corresponding author including email, mailing address and telephone numbers. Academic affiliations are required for all co-authors.

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4. Submitting your article, and what happens after submission.

a) **How to submit your manuscript.** *Palliative Medicine* is hosted on SAGE Track, a web based online submission and peer review system powered by ScholarOne™ Manuscripts. Visit http://mc.manuscriptcentral.com/palliative-medicine to login and submit your article online.
You will be asked to provide contact details and academic affiliations for all co-authors and identify who is to be the corresponding author.
You will be asked to submit a completed author's checklist which can be downloaded HERE, and also to upload a publishing guideline checklist (e.g. CONSORT, COREQ or PRISMA).These are downloadable from the EQUATOR network here. You may also upload other supplementary files (e.g. data files, large tables etc.).
IMPORTANT: Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past year it is likely that you will have had an account created. For further guidance on submitting your manuscript online please visit ScholarOne™ Online Help.

b) **ORCID.** As part of our commitment to ensuring an ethical, transparent and fair peer review process SAGE is a supporting member of ORCID, the Open Researcher and Contributor ID. ORCID provides a persistent digital identifier that distinguishes one researcher from every other researcher and, through integration in key research workflows such as manuscript and grant submission, supports automated linkages between researchers and their professional activities ensuring that their work is recognised. We encourage all authors to add their ORCIDs to their SAGE Track account. If you don't already have one you can create one here.

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d) **Peer review policy**. *Palliative Medicine* operates a conventional single blind reviewing policy in which the reviewer's name is always concealed from the submitting authors. Once reviews have been secured, we will either make the decision to decline the paper, or ask for revisions before we can consider the paper further. Papers accepted for publication following external review usually require some modification before final acceptance.

As part of the submission process you will be asked to provide the names of peers who could be called upon to review your manuscript. Recommended reviewers should be experts in their fields and should be able to provide an objective assessment of the manuscript. Please be aware of any conflicts of interest when recommending reviewers. Conflicts of interest to be considered include (but are not limited to):

The reviewer should have no prior knowledge of your submission
The reviewer should not have recently (last 3 years) collaborated with any of the authors
Reviewer nominees from the same institution as any of the authors are not permitted.

Please note that the editors are not obliged to invite any recommended/opposed reviewers to assess your manuscript.

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h) Publicising your paper. Publication is not the end of the process! You can help disseminate your paper and ensure it is as widely read and cited as possible. The SAGE Author Gateway has numerous resources to help you promote your work. Visit the Promote Your Article page on the Gateway for tips and advice. In addition, SAGE is partnered with Kudos, a free service that allows authors to explain, enrich, share, and measure the impact of their article. Find out how to maximise your article's impact with Kudos.

Palliative Medicine will publicise your published papers through its active social media presence including Twitter and Facebook. Some authors are invited to contribute to our Podcast series, and if you are particularly interested in recording a podcast to publicise your paper, please let us know. We also encourage authors to press release their paper in conjunction with their local or institutional press offices. If you are doing this, please let us know so that we can coordinate with any other publicity and social media. Each edition an author is also invited to blog for the EAPC blog as 'editors choice'.

Further information

Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the *Palliative Medicine* editorial office as follows:

Debbie Ashby
Editorial Manager
debbie.ashby@bristol.ac.uk

Manuscript Submission Guidelines

Pre-submission: helping readers find your article

Before you submit your manuscript, go back and review your title, keywords and abstract. These elements are key to ensuring that readers will be able to find your article online through online search engines such as Google. More information and guidance on how best to title your article, write your abstract and select your keywords can be found here: How to Help Readers Find Your Article Online.

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Think, check, submit is a trusted online service with a useful checklist that will help you determine whether you are submitting to the right journal. If you can answer 'yes' to most of their questions then you can be confident that your chosen journal is easily discoverable with a suitable reputation.

Editorial policies

Peer review policy
Please see the submission guidelines of the journal you wish to submit to. View the complete list of SAGE Journals.

Please note that as part of the submission process you may be asked to provide the names of a number of peers who could be called upon to review your manuscript. Recommended reviewers should be experts in their fields and should be able to provide an objective assessment of the manuscript. Please be aware of any conflicts of interest when recommending reviewers. Examples of conflicts of interest include (but are not limited to) the below:

- The reviewer should have no prior knowledge of your submission
- The reviewer should not have recently collaborated with any of the authors
- Reviewer nominees from the same institution as any of the authors are not permitted

Please note that the journal's editors are not obliged to invite any recommended/opposed reviewers to assess your manuscript.

Authorship
For authors submitting to technical or medical journals, papers should only be submitted for consideration once consent is given by all contributing authors. Those submitting papers should carefully check that all those whose work contributed to the paper are acknowledged as contributing authors.
The list of authors should include all those who can legitimately claim authorship. This is all those who:

1. Made a substantial contribution to the concept and design, acquisition of data or analysis and interpretation of data,
2. Drafted the article or revised it critically for important intellectual content,
3. Approved the version to be published.
4. Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Authors should meet the conditions of all of the points above. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.
When a large, multicentre group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship.

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For authors submitting to social science or humanities journals, all parties who have made a substantive contribution to the article should be listed as authors. Principal authorship, authorship order, and other publication credits should be based on the relative scientific or professional contributions of the individuals involved, regardless of their status. A student is usually listed as principal author on any multiple-authored publication that substantially derives from the student's dissertation or thesis.

Corresponding author

The one individual who takes primary responsibility for communication with the journal during the manuscript submission, peer review, and publication process, and typically ensures that all the journal's administrative requirements, such as providing details of authorship, ethics committee approval, clinical trial registration documentation, and gathering conflict of interest forms and statements, are properly completed, although these duties may be delegated to one or more co-authors.

The corresponding author is the person who signs the publishing agreement on behalf of all of the authors and whose contact details are included on the article. They should be available after publication to respond to critiques of the work and cooperate with any requests from the journal for data or additional information should questions about the paper arise after publication.

General guidance for authors submitting to medical journals (please view the relevant journal's submission guidelines for specific requirements)

Research ethics and patient consent

Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki

Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals, and all papers reporting animal and/or human studies must state in the methods section that the relevant Ethics Committee or Institutional Review Board provided (or waived) approval. Please ensure that you have provided the full name and institution of the review committee, in addition to the approval number.

For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.

Information on informed consent to report individual cases or case series should be included in the manuscript text. A statement is required regarding whether written informed consent for patient information and images to be published was provided by the patient(s) or a legally authorized representative.

Please also refer to the ICMJE Recommendations for the Protection of Research Participants

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Many SAGE journals conform to the ICMJE requirement that clinical trials are registered in a WHO-approved public trials registry at or before the time of first patient enrolment as a condition of consideration for publication. The trial registry name and URL, and registration number must be included at the end of the abstract.

Further to the above, other SAGE journals may consider retrospectively registered trials if the justification for late registration is acceptable, consistent with the AllTrials campaign. The trial registry name and URL, and registration number must be included at the end of the abstract.

Reporting guidelines
The relevant EQUATOR Network reporting guidelines should be followed depending on the type of study. For example, all randomized controlled trials submitted for publication should include a completed Consolidated Standards of Reporting Trials (CONSORT) flow chart as a cited figure, and a completed CONSORT checklist as a supplementary file.

Other resources can be found at NLM's Research Reporting Guidelines and Initiatives

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Preparing your manuscript

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Other styles available for certain journals are: ACS Style Guide, AMA Manual of Style, ASA Style Guide, Chicago Manual of Style and CSE Manual for Authors, Editors, and Societies.

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Equations should to be submitted using Office Math ML and Math type.

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ANEXO B – DECLARAÇÃO DE APROVAÇÃO DO COMITÊ DE ÉTICA EM PESQUISA COM SERES HUMANOS

UFS - UNIVERSIDADE FEDERAL DE SERGIPE

PARECER CONSUBSTANCIADO DO CEP

DADOS DO PROJETO DE PESQUISA

Título da Pesquisa: AVALIAÇÃO DA ABORDAGEM DOS CUIDADOS PALIATIVOS EM PACIENTES IDOSOS EM SERVIÇO DE URGÊNCIA DO HOSPITAL UNIVERSITÁRIO DE

Pesquisador: Fernando Every Belo Xavier

Área Temática:

Versão: 2

CAAE: 03399018.6.0000.5546

Instituição Proponente: Universidade Federal de Sergipe Campus Lagarto - Departamento de

Patrocinador Principal: Financiamento Próprio

DADOS DO PARECER

Número do Parecer: 3.144.456

Apresentação do Projeto:

Trata-se de um projeto de pesquisa com objetivo de elaboração de TCC do curso de Medicina,campus de Lagarto da Universidade Federal de Sergipe. O projeto possui financiamento próprio.

O presente estudo tem como objetivo avaliar a identificação e indicação dos cuidados paliativos em pacientes idosos no serviço de urgência do Hospital Universitário de Lagarto – SE, além de Comparar as respostas à "pergunta surpresa" entre os estudantes de medicina, o médico assistente e o familiar mais próximo ao paciente em que foram indicados os cuidados paliativos no Hospital Universitário de Lagarto – SE, descrever a abordagem dos sintomas utilizando a escada de sintomas de Edmonton Symptom Assessment System (ESAS) e verificar o desfecho final do paciente em acompanhamento de cuidados paliativos.

Objetivo da Pesquisa:

Objetivo Primário:

Avaliar a identificação e indicação dos cuidados paliativos em pacientes idosos no serviço de urgência do Hospital Universitário de Lagarto - SE

Objetivo Secundário:

1.Comparar as respostas à "pergunta surpresa" entre os estudantes de medicina, o médico

Endereço: Rua Cláudio Batista s/nº
Bairro: Sanatório **CEP:** 49.060-110
UF: SE **Município:** ARACAJU
Telefone: (79)3194-7208 **E-mail:** cephu@ufs.br

assistente e o familiar mais próximo ao paciente em que foram indicados os cuidados paliativos no Hospital Universitário de Lagarto – SE2.Descrever a abordagem dos sintomas utilizando a escada de sintomas de Edmonton Symptom Assessment System (ESAS)3.Verificar o desfecho final do paciente em acompanhamento de cuidados paliativos

Avaliação dos Riscos e Benefícios:

Conforme a Resolução CNS 466/12 todas as pesquisas envolvendo humanos possuem riscos. Nesta pesquisa os riscos envolvidos incluem

desconforto emocional por parte do paciente ou familiares quando forem abordados os temas mortes e finitude, além do próprio cuidado paliativo.

Qualquer desconforto emocional será acolhido pela equipe, e caso o paciente solicite, a entrevista será interrompida.

Reforça-se que esta pesquisa não irá tomar ou alterar condutas médicas que afetarão a linha de cuidado do paciente, sendo apenas realizados questionários e revisão de prontuários. Os dados coletados serão mantidos em sigilo e serão usados apenas pela equipe de pesquisa para análise estatística.

Benefícios:

A carência de estudos sobre este tema é alta, e não existem dados sobre a aplicação de cuidados paliativos na cidade de Lagarto-SE, assim como não há estudos sobre a identificação e a indicação de cuidados paliativos pela equipe de urgência, sendo por vezes subestimada a necessidade de uma equipe exclusiva para este fim. Tentar entender o processo de identificação destes pacientes com esta necessidade e a referência às equipes de cuidados paliativos pode ajudar aos serviços desta região a incentivar e a estruturar equipes dedicadas a este fim, proporcionado uma linha de cuidado mais adequada e humanizada a esta população.

Comentários e Considerações sobre a Pesquisa:

Projeto exequível.Serão realizadas entrevistas e aplicação de questionários validados em paciente, familiares e equipe assistente, além da revisão do prontuário do paciente internados nas enfermarias do Hospital Universitário de Lagarto – SE.

Considerações sobre os Termos de apresentação obrigatória:

Os termos de apresentação obrigatória foram apresentados.

Conclusões ou Pendências e Lista de Inadequações:

Os pesquisadores do projeto de pesquisa atenderam as recomendações apresentadas no parecer anterior.

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Continuação do Parecer: 3.144.456

Considerações Finais a critério do CEP:

Este parecer foi elaborado baseado nos documentos abaixo relacionados:

Tipo Documento	Arquivo	Postagem	Autor	Situação
Informações Básicas do Projeto	PB_INFORMAÇÕES_BÁSICAS_DO_PROJETO_1236281.pdf	27/12/2018 16:47:18		Aceito
Projeto Detalhado / Brochura Investigador	PROJETO_V1.doc	27/12/2018 16:46:14	Fernando Every Belo Xavier	Aceito
Parecer Anterior	PB_PARECER_CONSUBSTANCIADO_CEP_3087633.pdf	27/12/2018 16:43:03	Fernando Every Belo Xavier	Aceito
Declaração de Instituição e Infraestrutura	CARTA_ANUENCIA.pdf	27/12/2018 16:42:25	Fernando Every Belo Xavier	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	TCLE.docx	27/12/2018 16:17:02	Fernando Every Belo Xavier	Aceito
Folha de Rosto	Scan0001.pdf	23/11/2018 16:10:46	Fernando Every Belo Xavier	Aceito
Outros	ENTREVISTA_QUESTIONARIOS.docx	12/10/2018 13:46:59	Fernando Every Belo Xavier	Aceito

Situação do Parecer:
Aprovado

Necessita Apreciação da CONEP:
Não

ARACAJU, 13 de Fevereiro de 2019

Assinado por:
Anita Hermínia Oliveira Souza
(Coordenador(a))

Endereço: Rua Cláudio Batista s/nº
Bairro: Sanatório **CEP:** 49.060-110
UF: SE **Município:** ARACAJU
Telefone: (79)3194-7208 **E-mail:** cephu@ufs.br

ANEXO C – TERMO DE CONSENTIMENTO LIVRE E ESCLARECIDO

UNIVERSIDADE FEDERAL DE SERGIPE
CAMPUS UNIVERSITÁRIO PROF. ANTÔNIO GARCIA FILHO
DEPARTAMENTO DE MEDICINA DE LAGARTO

TERMO DE CONSENTIMENTO LIVRE E ESCLARECIDO

O (A) senhor (a) foi convidado (a) a participar da pesquisa intitulada "**Avaliação da abordagem dos cuidados paliativos em pacientes idosos em serviço de urgência do Hospital Universitário de Lagarto**" conduzida pelo discente Victor Gabriel Santana Cruz e orientada pelos Profª. Dr. Fernando Every Belo Xavier e Rivia Siqueira Amorim. O objetivo deste estudo é avaliar a qualidade dos cuidados paliativos empregados neste hospital, para que possam ser planejadas ações específicas para esta área.

Sua contribuição consistirá em participar de uma breve entrevista. Nesta entrevista, o (a) senhor (a) irá responder algumas perguntas feitas pelos atendentes, e a partir destas perguntas nós obteremos as informações necessárias para a nossa pesquisa.

Além dessas perguntas, também vamos realizar aplicação de questionários a fim de classificar as suas doenças e sintomas

Também gostaríamos de informar que iremos ler o seu prontuário, mas garantimos que o sigilo sobre ele será mantido e suas informações serão usadas apenas para o estudo.

Fique ciente de que você não será obrigado (a) a realizar nenhuma atividade para qual eu não se sinta disposto (a) ou capaz, a sua identidade será preservada e sua não participação no estudo não comprometerá nos seus cuidados durante a internação hospitalar. Os resultados obtidos pelo estudo serão publicados em veículos de divulgação científica, mas você não identificado (a) de qualquer forma.

Conforme a Resolução CNS 466/12 todas as pesquisas envolvendo humanos possuem riscos. Nesta pesquisa os riscos envolvidos incluem desconforto emocional por parte do paciente ou familiares quando forem abordados os temas mortes e finitude, além do próprio cuidado paliativo. Qualquer desconforto emocional será acolhido pela equipe, e caso o paciente solicite, a entrevista será interrompida.

Reforça-se que esta pesquisa não irá tomar ou alterar condutas médicas que afetarão a linha de cuidado do paciente, sendo apenas realizados questionários e revisão de prontuários.

Lembre-se ainda que o (a) senhor (a) poderá solicitar a qualquer momento que seus dados sejam removidos da pesquisa, sem que haja qualquer prejuízo.

Caso haja qualquer dúvida, problemas ou caso queira remover seu nome desta pesquisa, o (a) senhor (a) poderá entrar em contato com os responsáveis pelo estudo através dos seguintes contados:

- Rivia Siqueira Amorim: e-mail: riviasiq@hotmail.com ou (79) 99958-7144
- Victor Gabriel Santana Cruz: e-mail: victorgabriel28@gmail.com ou (79)99986-5315

Conforme a resolução CNS 466/12, este Termo de Consentimento é apresentado em duas vias, sendo que uma cópia ficará sob posse do entrevistado e outra do entrevistador.

Lagarto, _____ de _____ de _____

_____
Assinatura do participante ou responsável legal

_____
Assinatura do pesquisador

_____
Assinatura do Professor Dr. Fernando Every Belo Xavier

_____
Assinatura da Professora Rivia Siqueira Amorim

ANEXO D – FORMULÁRIO USADO NA ENTREVISTA E COLETA DE DADOS DO PRONTUÁRIO

UNIVERSIDADE FEDERAL DE SERGIPE
CAMPUS UNIVERSITÁRIO PROF. ANTÔNIO GARCIA FILHO
DEPARTAMENTO DE MEDICINA DE LAGARTO

1. IDENTIFICAÇÃO

NOME:	
IDADE:	
SEXO:	
LEITO:	
PROCEDÊNCIA:	
DEMANDA:	( ) BUSCA ATIVA / ( ) PEDIDO DE INTERCONSULTA
DIAGNÓSTICO DE BASE:	
ESTÁGIO:	

2. ÍNDICE DE COMORBIDADES DE CHARLSON

ÍNDICE DE COMORBIDADE DE CHARLSON (CHARLSON, 1987).	
Infarto do miocárdio	1
Insuficiência Cardíaca Congestiva	1
Doença Vascular Periférica	1
Doença Vascular Cerebral (exceto hemiplegia)	1
Demência	1
Doença Pulmonar Crônica	1
Doença do Tecido Conectivo	1
Úlcera	1
Doença Hepática leve	1
Diabetes (sem complicações)	1
Diabetes (com lesão de órgão alvo)	2
Hemiplegia	2
Doença Renal moderada ou severa	2
Tumor Sólido Secundário (não metastático)	2
Leucemia	2
Linfoma, Mieloma múltiplo	2
Doença hepática moderada ou severa	3
Tumor Sólido Metastático	6
SIDA	6
TOTAL	____
IDADE (ANOS)	
50-59	1
60-69	2
70-79	3
80-89	4
90-99	5
Total combinado (Comorbidades + Idade)	____

3. PERGUNTA SURPRESA AO ESTUDANTE DE MEDICINA RESPONSÁVEL PELO CASO

_____

4. PERGUNTA SURPRESA AO MÉDICO ASSISTENTE DO SETOR

_____

5. PERGUNTA SURPRESA AO PRINCIPAL FAMILIAR DO PACIENTE

_____

6. AVALIAÇÃO PELO NECPAL DO PACIENTE

Pergunta surpresa (para / entre profissionais)	Você ficaria surpreso se esse paciente morresse no próximo ano?		Não (+) Sim (-)
	Pergunta ao familiar mais próximo		
	Pergunta ao médico assistente		
	Pergunto ao interno que acompanha o paciente		
"Demanda" ou "necessidade"	Demanda: o paciente, a família ou a equipe solicitou de forma implicira ou explicita cuidados paliativos ou limitação do esforço terapêutico?		Sim/Não
	Necessidade: identificado por profissionais de saúde da equipe		Sim/Não
Indicadores clínicos gerais: 6 meses **- Grave, sustentado, progressivo, não relacionado com processo concorrente recente** **- Combina gravidade com progressão**	Declínio nutricional	Perda de peso > 10%	Sim/Não
	Declínio funcional	- Karbofsky ou Barthel > 30% - Perda > ADLs	Sim/Não
	Declínio cognitivo	Declinio no minimental/Pfeiffer	Sim/Não
Dependência severa	Karnofsky < 50 ou Barthel < 20		Sim/Não
Síndromes geriátricas	- Quedas - Disfagia - Infecções recorrentes - Úlcera por pressão - Delírium	Registro no prontuário - Recorrente > 2 - ou persistente	Sim/Não
Sintomas persistentes	Dor, fraqueza, anorexia, dispneia, digestivo...	Checklist de sintomas (ESAS)	Sim/Não
Aspectos psicossociais	Aflição e/ou desordem adaptativa grave	Escala de malestar emocional (DME) > 9	Sim/Não
	Vulnerabilidade social severa	Avaliação social e familiar	Sim/Não
Multi morbidades	>2 doenças crônicas (da lista de indicadores específicos)	Índice de Charlsson	Sim/Não
Uso de recursos	Avaliar a demanda / intensidade das intervenções	- > 2 entradas urgentes ou não planejadas nos últimos 6 meses - Aumentar a demanda / intensidade de intervenções (cuidados domiciliares, intervenções de enfermagem, etc.)	Sim/Não
Indicadores específicos	Câncer, DPOC, DAC, hepatopatia, nefropatia, doença cerebrovascular, demência, doença neurodegenerativa, AIDS, outras avançadas		Sim/Não

7. INDICAÇÃO DE PALIATIVOS SIM OU NÃO:

_____

8. PALLIATIVE PERFORMANCE SCALE (PPS)

Quadro 1 – Palliative *Performance* Scale (PPS)

%	Deambulação	Atividade e evidência de doença	Autocuidado	Ingesta	Nível da consciência
100	Completa	Atividade normal e trabalho, sem evidência de doença	Completo	Normal	Completo
90	Completa	Atividade normal e trabalho, alguma evidência de doença	Completo	Normal	Completo
80	Completa	Atividade normal com esforço, alguma evidência de doença	Completo	Normal ou reduzida	Completo
70	Reduzida	Incapaz para o trabalho, doença significativa	Completo	Normal ou reduzida	Completo
60	Reduzida	Incapaz para *hobbies*/ trabalho doméstico, doença significativa	Assistência ocasional	Normal ou reduzida	Completo ou períodos de confusão
50	Maior parte do tempo sentado ou deitado	Incapacitado para qualquer trabalho, doença extensa	Assistência considerável	Normal ou reduzida	Completo ou períodos de confusão
40	Maior parte do tempo acamado	Incapaz para a maioria das atividades, doença extensa	Assistência quase completa	Normal ou reduzida	Completo ou sonolência, +/- confusão
30	Totalmente acamado	Incapaz para qualquer atividade, doença extensa	Dependência completa	Normal ou reduzida	Completo ou sonolência, +/- confusão
20	Totalmente acamado	Incapaz para qualquer atividade, doença extensa	Dependência completa	Mínima a pequenos goles	Completo ou sonolência, +/- confusão
10	Totalmente acamado	Incapaz para qualquer atividade, doença extensa	Dependência completa	Cuidados com a boca	Sonolência ou coma, +/- confusão
0	Morte	–	–	–	–

Fonte: Victoria Hospice Society. J Pall Care, v. 9, n. 4, p. 26-32. Tradução livre de Maria Goretti Maciel/ Ricardo Tavares de Carvalho.

9. ESCALA DE ZUBROD (ECOG) E ESCALA DE KARNOFSKY (KPS)

Escala de Zubrod (ECOG)	Escala de Karnofsky (%)
PS 0 - Atividade normal	**100** - nenhuma queixa: ausência de evidência da doença
	90 - capaz de levar vida normal; sinais menores ou sintoma da doença
PS 1 - Sintomas da doença, mas deambula e leva seu dia a dia normal	**80** - alguns sinais ou sintomas da doença com o esforço
	70 - capaz de cuidar de si mesmo; incapaz de levar suas atividades normais ou exercer trabalho ativo
PS 2 - Fora do leito mais de 50% do tempo	**60** - necessita de assistência ocasional, mas ainda é capaz de prover a maioria de suas atividades
	50 - requer assistência considerável e cuidados médicos freqüentes
PS 3 - No leito mais de 50% do tempo, carente de cuidados mais intensivos	**40** - incapaz; requer cuidados especiais e assistência
	30 - muito incapaz; indicada hospitalização, apesar da morte não ser iminente
PS 4 - Preso ao leito	**20** - muito debilitado; hospitalização necessária; necessitando de tratamento de apoio ativo
	10 - moribundo, processos letais progredindo rapidamente